# Ranfurly Village Hospital Limited - Bob Reed, Ranfurly Care & Veterans

## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Ranfurly Village Hospital Limited

**Premises audited:** Ranfurly Village

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 17 August 2021 End date: 17 August 2021

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 60

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Ranfurly Village Hospital Ltd is privately owned. A health services manager/registered nurse is employed and responsible for the daily operations of the service. A care manager and stable workforce support her. The service provides rest home and hospital level of care for up to 60 residents. On the day of the audit, there were 60 residents.

The residents and relatives spoke very positively about the care provided at Ranfurly Village Hospital.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff and the general practitioner.

This audit identified one shortfall around completion of neurological observations when these were required to be taken.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

The service has a culture of open disclosure. Families are regularly updated of residents’ condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

The service has a health services manager who provides operational management along with the care manager who provides oversight of the clinical component of service delivery. Registered nurses, health care assistants, and support staff work to deliver services.

A quality and risk management programme includes a service philosophy and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes and results. Resident and family meetings are held, and satisfaction is monitored via annual satisfaction surveys.

Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated.

There is a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a staffing roster developed that meets the needs of residents.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of low risk. |

The registered nursing staff are responsible for each stage of service provision. The sample of residents’ records reviewed provides evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status.

The diversional therapist has developed an activity programme to promote resident independence, involvement, emotional wellbeing and social interaction appropriate to the level of physical and cognitive abilities of the rest home and hospital level residents.

Medication polices reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education and medication competencies. The medication charts reviewed meet prescribing requirements and had been reviewed at least three-monthly.

Food services and all meals are prepared on site. Resident’s individual food preferences and dislikes are known by kitchen staff and those serving the meals. There is dietitian review of the menu. Choices are available and are provided, with nutritious snacks being available 24 hours per day.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The building has a current building warrant of fitness certificate and all external areas were accessible and of an appropriate standard. There is a preventative and planned maintenance schedule in place. Ongoing maintenance issues are addressed. Chemicals are stored safely on site. The outdoor areas are safe and easily accessible.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

There are policies and procedures on safe restraint use and enablers. There was one resident voluntarily using enablers and five residents with restraints (bedrails). The care manager (registered nurse) is the restraint coordinator. Staff receive training around restraint and challenging behaviours. Assessment and evaluation processes are implemented.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The infection control management system is appropriate for the size and complexity of the service. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff and residents are offered the annual flu vaccine in addition to the Covid-19 vaccine. There have been no outbreaks.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 15 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 1 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal, email and written on the complaints form is maintained by the health services manager using a complaints’ register. There were eight resident/family related complaints to date for 2020 and four in 2021 to date.  Four complaints were reviewed, and this confirmed that complaints have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint in a timely manner. Residents and family members interviewed confirmed that they are aware of the complaints’ procedure. The health services manager and care manager were interviewed along with the following staff: six HCAs, three RNs, the head chef, diversional therapist, physiotherapy assistant/diversional therapist, maintenance staff, who confirmed discussion around concerns, complaints and compliments at facility meeting minutes as evidenced in the meeting minutes.  Complaints forms and a suggestion box is at the main entrance. This is checked weekly by the health services manager or delegated.  There have not been any complaints lodged by an external provider since the last audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Management promotes an open-door policy. Relatives/residents are aware of the open-door policy and confirmed on interview that the staff and management are approachable and available.  The ten residents (three from the rest home and seven from the hospital) and three family with relatives in the hospital interviewed, confirmed they were given an explanation about the services and procedures and were orientated to the facility as part of the entry process. They also stated their relatives are informed of changes in health status and incidents/accidents with family interviewed confirming that they were kept informed at all times. A review of 17 incident forms confirmed that family were informed in a timely manner when incidents occurred.  Residents and family stated that they have had good communication with managers during Covid with clear guidelines laid out around visiting according to the level restrictions during the pandemic.  Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available through the District Health Board with phone numbers identified in policy. There are staff on site who speak a range of languages. There are no residents currently requiring the use of interpreting services. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Ranfurly Village Hospital Ltd is privately owned. The service has a working relationship with the veteran’s trust. Veterans are given priority for admission. The service provides rest home and hospital level of care for up to 60 residents. All beds are dual-purpose within a new purpose-built facility. There are 30 beds on level two, and 30 beds on level three. On the day of audit there were 13 rest home residents and 47 hospital residents. All residents were under the ARCC.  The service is managed by a health services manager who is a registered nurse (RN). The health services manager has been in the role for four years, has previous management experience and 17 years’ experience in aged care. The health services manager is supported by a care manager who has 25 years’ experience in aged care.  There is a documented business plan. The previous business plan (2020-2021) was reviewed prior to the documentation of the 2021 to 2022 plan. There are two monthly quality meetings, and these include review of goals in the business plan.  The health services manager and care manager both maintain an annual practicing certificate and have maintained at least eight hours annually of professional development that is related to managing a rest home and hospital. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The service has a quality risk management plan in place. The service has implemented policies and procedures to support service delivery with these reviewed at regular intervals and at least two-yearly. Staff are required to sign the reading sheet to acknowledge they have read new/reviewed policies. A document control process is in place.  Meetings include weekly management meetings, monthly staff meetings, two monthly quality, quarterly household and kitchen meetings, health, and safety (including infection control) every two months and two monthly clinical meetings. There are resident meetings three times a year with family welcome to attend these. The service had trialled having a separate family meeting however this had a very low attendance and there is now a quarterly newsletter and communication by email.  Meeting minutes evidence discussion around quality data including complaints, compliments, health and safety, accident/incident, infection control, internal audit results and survey results. Internal audits are completed as scheduled. Corrective action plans are completed for any corrective actions required with evidence that these are resolved in a timely manner. There is a monthly quality report to the health services manager and facility meetings. Trends are identified and analysed for areas of improvement. Staff confirmed on interview they were kept informed on quality data including corrective actions and quality initiatives.  Satisfaction surveys were completed in the final months of 2019 and 2020. Both showed a high level of satisfaction with 84% satisfied or very satisfied with all areas identified in the survey in 2020. There were no consistent areas for improvement noted in the responses.  The service has a health and safety programme in place. The service addresses health and safety by recording hazards and near misses, sharing of health and safety information and actively encourage staff input and feedback. The health and safety representative (interviewed) stated the health and safety committee of representatives across the services were involved in the development and review of health and safety goals. Staff are given the opportunity to provide input into the two monthly health and safety committee meetings. The health and safety committee review monthly accident/incident reports and review the hazard reports and register. Health and safety information is displayed on the staff noticeboard. The representative interviewed has been involved with the contractors regularly. The village area under construction is cordoned off safely and a hazard board was in place. The service ensures that all new staff and any contractors are inducted to the health and safety programme with a training completed by staff as part of orientation (staff records confirmed that these had been completed). Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.  There have been a number of improvements in the service since the last audit. They include improvements in attendance at training sessions, improvements in the activities programme to include more innovative ways to engage with residents, putting a lounge carer in place to monitor residents at risk of falling, staff wellness, and a review of use of cleaning products to improve effectiveness. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | As part of the risk management and health and safety framework, there is an accident/incident policy. All incidents are logged onto an online data base by the RNs. The care manager reviews all incidents daily and documents a monthly report to the management, health and safety committee, clinical and facility meetings. Accident/incident data, trends and corrective actions are documented in meeting minutes sighted.  Seventeen incident forms were reviewed. All incident forms identified timely RN assessment of the resident and corrective actions or recommendations that had been completed and signed off by the health services manager or care manager. Neurological observations had not been completed for all unwitnessed falls or for any known head injury (link 1.3.6.1). The healthcare assistants interviewed could discuss the incident reporting process.  The health services manager could describe situations that would require reporting to relevant authorities. The service has not had to report any serious events to external authorities. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies to support recruitment practices. The register of RN practising certificates and allied health professionals is current. Six staff files were reviewed (health services manager, two RNs, two healthcare assistants, one diversional therapist). All files contained relevant employment documentation including a signed contract, job description, current performance appraisals and completed orientations. The orientation programme provides new staff with relevant information for safe work practice. Care staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.  The educator manages the education for the service. The education plan is developed annually and reviewed six-monthly to ensure that training is appropriate to resident care needs and/or any issues that have arisen. The education plan covers all the mandatory education requirements. Registered nurses have access to external training that includes clinical education relevant to medical conditions. In-service attended on site delivered by external educators includes end of life/palliative care, loss and grief, diabetes, and wound care. Seven of the eight RNs are interRAI competent. Staff complete competencies relevant to their roles.  There are long term HCAs who have been with the service for over 10 years. All have completed either level three or four CareerForce with new staff encouraged to gain certificates from CareerForce after orientation has been completed. Healthcare assistants interviewed included staff with level three and four qualifications with those interviewed having worked for five, 19, 23 or 25 years. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered to manage the care requirements of the residents.  The staffing includes the health service manager and the clinical manager Monday to Friday. Senior RNs are on call with this escalated to the health service manager or the clinical manager.  There are two floors in the building with two wings on each floor. These are level 1 with Wallingford (11 hospital and four rest home residents) and McKay with (11 hospital and four rest home residents); and level two with Knox (13 hospital and two rest home residents) and Wallace (13 hospital and two rest home residents). Each floor has the same roster as follows: there are four HCAs on duty in the morning (long shift), two long in the afternoon along with one HCA from 1630 to 2030 and one from 1445 to 2000. There are two HCAs on duty overnight. There is an HCA on duty from 0645 to 1500 and they help as required on either floor or support residents with menu ordering five days a week. There is one RN on each floor in the morning with an extra RN on duty three days a week in the morning. There are two RNs on duty (one on each floor) on the afternoon shift and one overnight. For three nights a week there are two RNs.  There are designated staff for activities, cleaning and laundry services and food services.  Interviews with residents and family members identified that staffing is adequate to meet the needs of residents. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were four residents self-administering on the day of audit. All four had the required GP assessments and three-monthly reviews of their ongoing capacity to self-medicate and safe storage of medications in their rooms. There are no standing orders in use. There are no vaccines stored on-site. All clinical staff (RNs, med-comp health care assistants) who administer and/or check medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. The registered nurses (interviewed) could describe their role regarding medication administration. The service currently uses robotics for regular medication and ‘as required’ medications. All medications are checked on delivery against the medication chart (Medimap) and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the facility medication room. The medication fridge and room temperatures are monitored daily. Temperatures were within acceptable ranges. All eyedrops have been dated on opening.  Staff sign for the administration of medications electronically. Ten electronic medication charts were reviewed. The medication charts reviewed identified that the GP had reviewed all resident medication charts three monthly. Each drug chart has a photo identification and allergy status identified. ‘As required’ medications had indications for use charted. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The meals at Ranfurly Village are all prepared and cooked on site. The kitchen was observed to be clean, well-organised, well equipped and a current approved food control plan was in evidence. There is a four-weekly seasonal menu that is reviewed by an external registered dietitian. The chef receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, pureed foods) or of any residents with weight loss. The head chef (interviewed) is aware of resident likes, dislikes and special dietary requirements. Alternative meals are offered for those residents with dislikes or religious preferences. Residents have access to nutritious snacks 24 hours a day. On the day of audit, meals were observed to be well presented.  Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. Staff were observed wearing correct personal protective clothing in the kitchen. Cleaning schedules are maintained appropriately. Staff were observed assisting residents with meals in the dining areas and modified utensils are available for residents to maintain independence with meals. Food services staff have all completed food safety and hygiene courses. There is a food control plan expiring September 2022.  The residents interviewed were satisfied with the food service and the variety and choice of meals provided. They can offer feedback on a one-to-one basis, at the resident meetings and through resident surveys. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | The registered nurses complete care plans for residents. Progress notes in all files reviewed had details which reflected the interventions documented in the long-term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Short-term care plans are documented for changes in health status. Staff stated that they notify family members about any changes in their relative’s health status, and this was confirmed by family members interviewed, who stated they are notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Evidence of relative contact for any changes to resident health status was viewed in the resident files sampled. Care plans reviewed documented sufficient detail to guide care staff in the provision of care. The service is currently recruiting for a physiotherapist to assess and assist residents’ mobility and transfer needs as required. A physiotherapy assistant is also employed for 20 hours per week.  Wound assessment, appropriate wound management and ongoing evaluations are in place for all wounds. Wound monitoring occurred as planned and is documented on both on a paper based wound log and, in the residents’ clinical file. There were fifteen ongoing wounds including nine skin tears, one abrasion, two lesions, two chronic ulcers and one post-surgical wounds. There were no pressure injuries. The service can access the wound nurse specialist service for advice and input as required and there was evidence of this in chronic wound management.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies, and these were sighted on day of audit.  Monitoring charts sighted included (but are not limited to), vital signs, blood glucose, pain, food, and fluid, turning charts, neurological observations, bowel monitoring and behaviour monitoring. Not all monitoring requirements for neurological observations had been documented as required.  Care plans have been updated as residents’ needs changed. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There is one diversional therapist and activity coordinator covering Monday to Friday who plan and lead all activities. The diversional therapist prepares activity resources for weekends, with resources labelled and easily identifiable for HCAs and families to utilise as required. Residents were observed participating in planned activities during the time of audit.  There is a weekly programme which is given to each resident, emailed to families, and placed in large print on noticeboards in all areas. Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, cooking, crafts, games, quizzes, entertainers, pet therapy, art therapy and bingo.  Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as manicures, technology-based activities and hand massage are offered. All residents and families are able to access the dedicated activities room and use the Tovertafel system which is a virtual projector system, including active games, puzzles, and art sessions.  There are weekly outings utilising the facility’s own vehicle. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers’ Day and Anzac Day are celebrated in collaboration with the kitchen staff who provide birthday cakes and other themed goods for the residents. There are visiting community groups such as the tai chi group, churches and local schools.  Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.  Residents interviewed were very positive about the activity programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The organisation’s policy requires that care plans are reviewed six monthly or more frequently when clinically indicated. All initial care plans are evaluated by the RN within three weeks of admission. The written evaluations describe progress against the documented goals and needs identified in the care plan. Four of the five long-term care files sampled of permanent residents contained written evaluations completed six monthly as one rest home resident was a recent admission. Family are invited to attend review meetings and the GP reviews the resident at least three monthly and more frequently for residents with more complex problems. Ongoing nursing evaluations occur daily and/or as required and are documented in the progress notes.  Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files reviewed. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a building warrant of fitness which expires 3 October 2021. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.  Electrical equipment safety is ensured through a six-monthly RCD check by a qualified electrician. All electrical equipment on site runs through the RCD system. Items of medical equipment are calibrated annually and are next due to be checked December 2021. Hot water temperatures have been monitored in resident areas and are within the acceptable range.  There is a lift between floors which is large enough for a stretcher. It is checked and maintained. Flooring is safe and appropriate for residential care. All corridors have sufficient room in order to promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained. The indoor-outdoor flow from the level 2 lounge allows unrestricted access to a large paved outdoor area raised beds and seating area. There is safe access to all communal areas in the facility. All indoor and outdoor areas are fit for purpose and are easily accessible to residents. All outdoor areas have some seating and shade. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in the Ranfurly Village infection control policy. Effective monitoring is the responsibility of the infection control coordinator (care manager). An individual resident infection report is completed for all infections which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used for residents diagnosed with infections as evidenced in the resident files reviewed. Surveillance of all infections is entered onto a monthly infection summary, which the infection control coordinator uses to collate the data and analyse any trends arising.  The infection control coordinator provides infection control data, trends and relevant information to the facility management and care staff. Areas for improvement are identified, corrective actions developed and followed up. This data is monitored and evaluated monthly. If there is an emergent issue, it is acted upon in a timely manner. On review of the surveillance data the infection rate continues to be very low at the facility and there have been no outbreaks since the last audit.  Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. The majority of residents have received both doses of the Pfizer Covid-19 vaccine with staff vaccination ongoing in conjunction with the local DHB. Residents and staff are offered the influenza vaccine. Covid-19 scanning/manual sign in is mandatory on entry to the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The service only allows bed rails to be used as a restraint or enabler. restraints. On the day of the audit, there was one resident with an enabler and five residents with restraints. One resident file reviewed for enabler use identified the resident had given voluntary consent. Restraint and challenging behaviour education are included in the training programme. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

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| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | There are clear indications, requirements and timescales related to neurological observations in the organisation’s policy, however, not all neurological observations were carried out and documented as per that policy. | Neurological observations were not consistently documented according to organisational policy for five of fourteen residents with unwitnessed falls and/or a hit to the head. | Ensure all resident monitoring charts are fully completed in a timely manner and according to policy.  60 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

|  |
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| No data to display |

End of the report.