Wellness Enterprises Limited - Raglan Rest Home and Hospital

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 The DAA Group Limited, 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.

The specifics of this audit included:

Legal entity:	Wellness Enterprises Limited
Premises audited:	Raglan Rest Home and Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 19 April 2021 End date: 19 April 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: 33

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

Indicator	Description	Definition
	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

Raglan Rest Home and Hospital provides rest home and hospital level care to a maximum of 36 residents. The service is owned and operated by Wellness Enterprises Ltd. The facility management and day to day services are overseen by the owner who is an experienced registered nurse (RN) and provides clinical nurse leadership to the RNs and care staff.

There have been no significant changes to the scope of services or staffing since the previous certification audit.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the District Health Board (DHB). The audit process included review of documents including residents' and staff files, observations and interviews with residents and family members, the owner/manager, staff, and a general practitioner (GP).

Residents and their families spoke positively about the care provided.

Consumer rights

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.

Implemented systems and the environment is conducive to effective communication. The complaints management system meets the requirements of the Code and is known by staff, residents and their families. There have been no serious complaint investigations or any formal complaints submitted since the February 2019 certification audit. Residents and the family member interviewed reported that the manager immediately responds to and addresses any concerns they raise.

Organisational management

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 annual business and quality risk management plans include the scope, direction, goals, values and mission statement of the organisation. An experienced and suitably qualified person manages the services being delivered.

The quality and risk management system includes monitoring service delivery and other operations through internal audits. Quality improvement data is collected, analysed for trends and leads to improvements. Staff are involved, and feedback is sought from residents and families.

Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery.

The appointment, orientation and management of staff is based on good employment practices. A systematic approach to identify and deliver ongoing training, supports safe service delivery and includes regular individual performance review.

Staffing levels and skill mix meet the changing needs of residents.

Continuum of service delivery

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.		Standards applicable to this service fully attained.

Residents receive services in a competent and timely manner. The registered nurses (RNs) are responsible for completing nursing assessments, care plans and evaluations. Assessments were current and up to date. Interventions were adequate to meet the residents' assessed needs.

The planned activities provided were appropriate to meet the needs, age, culture, and setting of the service. The activities reflected the ordinary patterns of life and included involvement of other representatives and other community groups.

The service uses a pre-packaged medication system and electronic medication management system. Medication is administered by staff with current medication administration competencies. Medication reviews are completed by the general practitioner (GP) in a timely manner.

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. There is a current food control plan in place.

Safe and appropriate environment

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.

There have been no changes to the structure of the buildings since the previous audit. Building improvements for safety and enhancements are ongoing. There is a current building warrant of fitness.

Restraint minimisation and safe practice

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.

The service meets the requirements of the restraint minimisation and safe practice standards. There were no restraint interventions in place at the time of this audit.

Infection prevention and control

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 surveillance programme is suitable to the size and scope of the service. Infection rates are monitored and shared with staff and the owner/manager and clinical nurse leader. Data on infections is collated and analysed to identify trends.

Summary of attainment

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

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	16	0	0	0	0	0
Criteria	0	39	0	0	0	0	0

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.

For more information on the different types of audits and what they cover please click here.

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 policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew what to do if they had concerns. The owner/manager reported no formal complaints had been received since the previous certification audit. Issues or areas of concern raised by staff, families or residents are managed directly by the owner/manager who is on site each weekday and often works nursing shifts. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received or investigated by the DHB or the Office of the Health and Disability Commission since the previous audit.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	The family members interviewed said they were kept well informed about any changes to their relative's status and were advised in a timely manner about any incidents or accidents. Communication about the outcomes of, and invitations to participate in regular or urgent medical reviews were forthcoming. This was supported in the residents' records reviewed. Staff and the manager interviewed understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. There was one resident on site for whom English was a second language, but this person did not require an interpreter, as they were

conducive to effective communication.		able to articulate their needs and family visited frequently enough to assist with communication when required. All care staff were respectful of and understood this resident's expressed desires.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Raglan Rest Home and Hospital has a total capacity of 36 beds. The service provider has agreements with the Ministry of Health and Waikato DHB to provide services to people under 65 of years, age residential care for hospital geriatric and rest home services, long term support chronic health conditions (LTS-CHC) palliative care, respite/short term care, and a day activities programme. On the day of audit there were 33 residents on site. Of these, 18 residents were receiving rest home level care and five were receiving hospital level care. Four residents were on respite (two assessed as hospital level and two as rest home). There were six residents under the age of 65 years. Three were funded under the MoH contract for young people with disabilities and three under the LTS-CHC contract. The organisation has a clearly described scope, direction and goals documented in its annual strategic and quality plan. The service is managed by the owner/clinical nurse leader who is on site every weekday. This person is a New Zealand registered nurse with a Post Graduate Diploma in Gerontology and a certificate in public health nursing. The manager has held various clinical nurse and regional manager roles in residential disability and age care services. Interview confirmed that this person is maintaining essential skills and knowledge by attending regular professional development and industry conferences. The manager and all RNs had current first aid certificates.
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	Raglan Rest Home and Hospital continues its membership with The Cavell Group, a group of other age care providers who share a quality and risk system which includes a comprehensive set of policies and procedures. Policies are based on best practice and cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Control of these documents is moderated by all directors of the Cavell Group, who facilitate a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The quality system includes a schedule of internal audits, documentation and monitoring of any changes made as a result of an audit, management of incidents, including clinical incidents such as infections and complaints. Interview with the manager and the review of documents related to quality (for example, audit outcomes, results of incident data analysis and meeting minutes) confirmed use of the system and a commitment to quality improvement.

		The staff interviewed demonstrated knowledge, understanding and involvement with quality and risk management activities. Month by month analytical reports on incidents/accidents are discussed at monthly staff meetings. This was confirmed by review of meeting minutes and staff interviews. Feedback about specific services is sought from residents and their family members at regular resident and family meetings. Resident satisfaction surveys are completed annually. The most recent survey from 2020 showed no areas for concern. The manager is conversant with the Health and Safety at Work Act (2015) and has implemented its requirements. Review of the current risk management plan identifies all known risks and clearly described mitigation strategies.
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	There were well established and managed processes for the reporting, recording, investigation and review of all incidents and accidents. Review of onsite documents and interviews with staff and management confirmed these are reviewed and discussed at staff meetings. Avoidable events are evaluated and actions are implemented to prevent recurrence. Interviews and review of incident data confirmed that incidents are discussed at shift handover, and trending data is displayed in staff areas. Each resident's care record contained a summary of incidents which facilitates a ready review of risks. The manager/ owner is responsible for essential notifications and reporting and understood the statutory and regulatory obligations. There have been no section 31 notifications since the 2019 recertification audit.
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	Policies and processes for staff management are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. A staff member who had previously worked at the home was complimentary of the orientation process. Other new staff records reviewed showed documentation of completed orientation and a performance review after a three-month period. Continuing education is planned on an annual basis, including mandatory training requirements. Training to meet the needs of younger individuals with disabilities also occurs. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. On the day of audit, six of the 16 carers had completed level 4 of the National Certificate in Health and Wellness, three had completed level 3 and one was at level 2. The other six carers were either employed as casual staff, were new to the organisation or had

		been employed in their roles for many years. Three of the six RNs are maintaining annual competency requirements to undertake interRAI assessments. Each of the staff records reviewed contained evidence of required training attended and completion of annual performance appraisals.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. A new electronic rostering system enables immediate changes to staff levels, tracking of shifts worked and communication to all staff via their cell phones. There are four care staff on site every morning and three in the afternoon, plus an RN and the nurse manager during the weekdays. The nurse manager oversees all clinical care and completes nursing shifts to stay familiar with residents' care needs and the workload expected of staff. There is one RN and one care staff rostered on each night. Care staff interviewed said there were enough staff on each shift to complete the tasks allocated to them and that staff morale was good. Residents and family members interviewed supported this. An afterhours on call roster of RNs and GPs is in place, with staff reporting that good access to advice is available when needed. Observations and review of a four-week roster cycle confirmed more than adequate staff cover has been provided. Absent staff are usually replaced by employed staff doing additional hours. At least one staff member on each duty has a current first aid certificate.
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	Raglan Rest Home and Hospital has a safe electronic medication management system in place that was observed on the day of the audit. The medication management policy was current and identified all aspects of medicine management in line with safe practice guidelines and current legislative requirements. Staff who administer medication had current medication administration competencies. The RN who was observed administering medicines demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Medicines were stored safely in the locked cupboards and medicine trolley in the nurses' station. Staff have individual passwords to access the electronic medicine records. The medicine fridge and medication room temperatures were monitored, and the reviewed records were within the recommended ranges. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN completes medication reconciliation upon residents' readmission from acute services and when medication is received from the pharmacy. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Unwanted medicines are returned to the pharmacy. Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.

		The GP completed three-monthly medication reviews consistently, this was verified on electronic medicine charts reviewed. Dates were recorded on the commencement and discontinuation of medicines. Evaluation of pro re nata (PRN) medicines administered were completed consistently. There were no residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner when required. Interviewed staff demonstrated awareness of the medication self-administration process.
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	Residents' nutritional needs are identified on admission by the RNs and diet profiles are completed. Special dietary requirements, including likes, dislikes and allergies were identified and accommodated in the meal plan. Copies of the dietary forms were sighted in the kitchen file. Special equipment, to meet residents' nutritional needs, was available. The food service is provided on site by a chef and two cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns in a four-week cycle. The menu has been reviewed by a qualified dietitian on 31 March 2021. Recommendations made at that time have been implemented. The service operates with an approved and current food safety plan and registration issued by the Waikato District Council. Food temperatures were monitored appropriately and recorded as part of the plan. Fridge and freezer temperatures were monitored and documented as required. The kitchen was clean, no expired food was found in the pantry and left-over food was covered and dated. The cooks have completed a safe food handling training. The residents and family/whanau reported satisfaction with the food service, and this was verified in the satisfaction surveys sighted. On the day of the audit residents were given enough time to eat their meal in an unhurried fashion.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The interventions documented in the long-term care plans reviewed were adequate and appropriate to address residents' assessed needs and desired outcomes. Observations and interviews with residents and family/whanau verified that care provided to residents was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of residents' individualised needs was evident in all areas of service provision. The GP confirmed that medical input was sought in a timely manner, and care was provided as prescribed. Adequate equipment and resources were available to meet the residents' needs.

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	The activities programme is provided by the activities coordinator (AC) who is in the process of completing the level four diversional therapy training through Careerforce. She is supported by community volunteers. The AC completes the activities assessments for all residents with input from residents and family/whanau. There is a weekly activities calendar posted on the notice boards around the facility. A monthly calendar is emailed to family/whanau with some highlights on activities on the programme. The family/whanau are welcome to participate in activities with their family/relative. The activities on the schedule reflect ordinary patterns of life, were specific to the cultural needs of the residents and included community activities. Residents can participate in individual or group activities as desired. Residents below 65years have one-on-one activities planned to meet their individual needs and can join the activities on the calendar with the above 65 group if desired. Residents were observed participating in various activities on the day of the audit. The activities on the calendar included celebration of monthly themes, birthday celebrations, external entertainment, men's outings, van outings, discovery group, bible study, bowls, garden walks, quiz, puzzles, exercises, animal therapy, library interactive sessions, arts and crafts, newspaper reading and manicure. The residents' participation in activities was recorded daily and activity needs were evaluated as part of the formal six monthly interRAI and care plan review. The satisfaction survey verified residents' and family/whanau involvement in evaluating and improving the activities programme. The interviewed residents and family/whanau confirmed residents' satisfaction with the activities programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Long-term care plans and short-term care plans were evaluated by the RNs in a timely manner. Evaluations sighted were individualised and indicated the residents' degree of response to the interventions and progress towards achieving the desired outcome. Changes were made to the care plans where the desired goal was not met. The interviewed residents and family confirmed their involvement in the evaluation of progress and resulting changes. The long-term care plans sighted were signed by residents and family or enduring power of attorney where indicated.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their	FA	A building warrant of fitness was current and displayed at the entrance to the facility with an expiry date of 27 April 2021. The site had already been inspected and the provider was waiting for the new certificate to be issued. There have been no changes to the structure of the buildings. Significant enhancements to the home have occurred. This includes new carpets and wall coverings and replacement of equipment and furnishings. All buildings, plant and equipment inspected during the audit were in good condition and showed evidence of being well maintained. There have been no incidents related to the environment.

purpose.		
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	The infection surveillance carried out is in accordance with the agreed objectives specified in the infection control programme and is appropriate for the size and setting of the service. All identified infections were documented, monthly data was collated and analysed. Recommendations and corrective actions to assist with reducing and preventing infections were acted upon. Short term care plans were implemented with appropriate interventions to manage the identified infections. New infections and any required management plans were discussed at handover, to ensure early intervention occurs. Monthly surveillance results were shared with staff in staff meetings. Comparisons against previous months were conducted and the reviewed infection statistics evidenced minimal infection rates. Covid-19 pandemic contact tracing measures were implemented. There was no infection outbreak reported since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility when required and demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities. On the days of audit there were no restraints in use. The register showed there had not been a restraint in use since 2019. Four residents were using overhead bed bars and two had bed levers as enablers to assist them to sit upright in bed. These were being used voluntarily and at the resident's request. This was confirmed by residents interviewed. Restraint is only used as a last resort when all alternatives have been explored. This was clearly documented in meeting minutes, past restraint records and staff interviewed.

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.

No data to display

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.

No data to display

End of the report.