West Otago Health Limited - Ribbonwood Country Home

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 Health and Disability Auditing New Zealand 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: West Otago Health Limited

Premises audited: Ribbonwood Country Home

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

Dates of audit: Start date: 13 June 2018 End date: 14 June 2018

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: 14

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

Ribbonwood Country Home is part of West Otago Health Limited. The service is certified to provide hospital services – geriatric and medical and rest home level care for up to 14 residents. There were 14 residents on the day of audit.

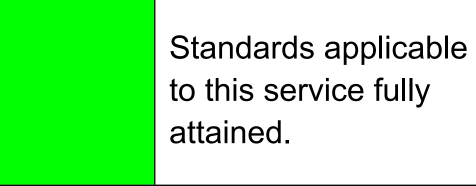
This surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family,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

A facility manager with support from the clinical manager, manages the service. Family and residents interviewed all spoke very positively about the care and support provided.

All three shortfalls identified at the previous audit have been addressed. These were around timeliness of documentation, medication administration and preventative maintenance.

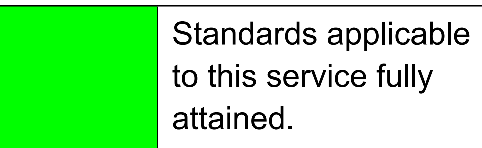
The audit identified two improvements required around resident care documentation and self-medicating residents' documentation.

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.

The service has an implemented culture of open disclosure. Residents and families interviewed reported they are kept well informed. Complaints processes are implemented and managed in line with the Code.

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.

Ribbonwood home is implementing a quality and risk management system that supports the provision of clinical care. Quality activities are conducted, and corrective actions have been developed and implemented. The service has a culture of health and safety. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The registered nurses are responsible for care plan development with input from residents and family. A review of a sample of resident files identified that assessments, interventions and evaluations reflected current care.

Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medication management policies and procedures are documented in line with legislation and current regulations. Medication administration records demonstrate medications are administered as prescribed.

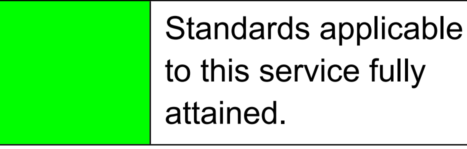
Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

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.

The service has a current building WOF and reactive and preventative maintenance is completed.

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.

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents with enablers and one resident with restraint. Training and audits have been completed.

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 type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	14	0	1	1	0	0
Criteria	0	39	0	1	1	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	There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The facility manager is responsible for complaints management. There was one complaint in 2017 and two in 2018 for the year-to-date. Review of the three complaints demonstrated that they had been managed which meet the requirements of Code 10 of the Code of Rights. Investigation of concerns/complaints are conducted, with input from the clinical manager for clinical and care issues. Complaints forms are visible and available for relatives/residents. A complaints procedure is provided to residents within the information pack at entry. A complaints register is available. Complaints are a standing agenda item at staff, residents' and quality meetings. Management operate an 'open door' policy.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	There is a policy to guide staff on the process around open disclosure. The facility manager and registered nurses interviewed confirmed that family are kept informed. Relatives (three hospital) stated they are notified promptly of any incidents/accidents. Each of the 12 incident forms reviewed documented that family had been informed of the incident. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). There is access to an interpreter service as required.

conducive to effective communication.		
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Ribbonwood provides care for up to 14 rest home and hospital (geriatric and medical) level care residents. On the day of audit, there were 14 residents - nine rest home (including one respite), and five hospital residents. All permanent residents were under the aged related contract. All rooms at Ribbonwood are dual-purpose (rest home or hospital). The respite resident is funded by ACC. The facility is attached to the West Otago Health services, which provides primary and community care. A resident general practitioner (GP) provides medical care to the residents, and afterhours and on-call services are provided by the GP and PRIME trained registered nurses. The service has access to a physiotherapist who works in the medical centre. The service has a current strategic plan and a business plan for 2018. The business plan identifies the purpose, values and scope of the business. The quality and risk management plan outline the quality goals, which are reviewed at the quality meeting. A trust board governs the service. The board meets six weekly and receives reports from the facility manager on all aspects of service delivery at Ribbonwood. The GP and the clinical manager provide clinical oversight at Ribbonwood. The facility manager (RN) who was previously the clinical manager and the clinical manager (previously a senior RN at Ribbonwood) both began their roles in an acting capacity on 1 January 2018, and both positions became permanent on 1 June 2018. The facility manager has completed at least eight hours of professional development related to managing an aged care facility.
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	FA	Ribbonwood is implementing a quality and risk management system. The facility manager and the clinical manager oversee the quality programme. The quality programme includes goals for 2018. Policies and procedures implemented provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff confirmed they are made aware of any new/reviewed policies. The quality programme and quality activities conducted are reviewed via the three-monthly staff meetings and six-monthly quality meetings. Meeting minutes sighted evidence discussion around accident/incident data, health and safety, infection control, audit outcomes, and complaints and concerns. A resident survey undertaken in November 2017 had very positive results and a relative survey the same month had 100% satisfaction. The service collates accident/incident and infection control data. Meeting minutes, monthly data comparisons, trends and graphs are available for staff information. Staff interviewed (two registered nurses, two caregivers and one activities

principles.		coordinator) were aware of quality data results, trends and corrective actions. An internal audit programme covers all aspects of the service. The outcomes of internal audits are discussed with staff at the various meetings. Corrective actions have been developed and implemented for shortfalls in service identified. There is an implemented health and safety programme in place including policies to guide practice. There are designated health and safety staff representatives and external training was attended in March 2018. Current hazard registers have been developed for all service areas and are easily located for staff. Staff confirmed they are kept informed on health and safety matters at meetings. There is a current emergency/business continuity plan. Fall prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.
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	A sample of 12 accident/incident forms were reviewed. There had been timely clinical assessment of residents completed by a registered nurse apart from neuro observations (link 1.3.6.1). Accidents/incidents were also recorded in the resident progress notes sampled. The service collects incident and accident data and reports the data to the quality meeting and staff meeting. Staff interviewed confirmed incident and accident data are discussed at the various meetings and information and graphs are made available. Discussions with the management team confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in	FA	There are human resources policies to support recruitment practices. Five staff files sampled contained all relevant employment documentation and included one clinical manager, one registered nurse, one caregiver, one activities coordinator and one chef. Current practising certificates were sighted for registered nurses and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed advised that they completed an orientation programme prior to working independently. Employment documentation was evident in the sample of staff files reviewed. Annual appraisals were current in all files sampled.

accordance with good employment practice and meet the requirements of legislation.		There is an education planner in place for 2018 and is being implemented. Staff complete competencies relevant to their role. There are three interRAI trained RNs.
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 facility manager works 30 hours per week (Monday to Friday) and is available on call for any emergency issues or clinical support. There is one registered nurse and one caregiver on duty 24 hours per day. In addition, there is an activities coordinator with eight hours dedicated to activities each week. A staff availability list ensures that staff sickness and vacant shifts are covered. The clinical manager rotates shifts on the roster and had worked night shift the night before the audit so was not present for the early part of the audit. Caregivers and registered nurses interviewed confirmed that staff are replaced. Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. Residents (two rest home and two hospital) and family interviewed also advised that there were sufficient staff rostered on.
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.	PA Low	The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication records reviewed evidenced that medication has been administered as prescribed. This is an improvement since the previous audit. Ten medication records were reviewed. The registered nurses are responsible for the administration of medications. Staff who administer medication have been assessed as competent. The facility uses a blister pack medication management system for the packaging of all tablets. The RN reconciles the delivery of the packs from the pharmacy and documents this. Medication charts are documented electronically by the GP and there was evidence of three monthly reviews. Medications reviewed were prescribed and charted in line with guidelines. There were two residents self-administering and they did not have current competency assessments. The secure treatment room includes a medication fridge. The temperature of the fridge is monitored.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this	FA	The food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. The main chef works four days a week. She is supported by two experienced cooks who alternate the chef's days off. They prepare and cook all meals on-site. Both have completed food safety training. The summer and winter menus have been reviewed by a dietitian. Residents are provided with meals that meet their food, fluid and nutritional needs. The registered nurses complete the dietary requirement forms on admission and if there are any changes, and provide a copy to the kitchen. The service also provides additional or modified foods.

service is a component of service delivery.		Chiller, freezer and food temperatures are monitored and recorded daily. Cooked meals are plated from the kitchen directly to the dining room. The residents confirmed that they are provided with alternative meals as per request. All residents are weighed regularly. Residents with weight loss are provided with food supplements. Residents and family members interviewed spoke positively about the meals provided.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	The RN initiates a review and if required, a GP or nurse specialist consultation when a resident's condition changes. Care plans sampled addressed all residents' needs and goals and caregivers reported they are easy to follow. There is close registered nurse oversight with a registered nurse being on duty and undertaking clinical reviews 24 hours per day. However, neurological observations are not always completed when required. Relatives interviewed stated their relative's needs are met and they are kept informed of any health changes. There was documented evidence in the resident files of family notification of any changes to health, including infections, accidents/incidents, and medication changes. Residents interviewed stated their needs are being met. Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for one resident with a skin tear and a respite resident admitted two days prior to the audit with an unstageable pressure injury. The resident was admitted the day before the audit and the clinical manager was aware of the need to make a section 31 notification around this. The wound is being reviewed and dressed daily by the district nurse wound specialist. The resident has pressure relieving booties and is being nursed on a pressure mattress. Wounds are re-assessed at least monthly. Evaluation comments were documented at each dressing change to monitor the healing progress for both wounds. 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. There are a number of monitoring forms and charts available for use including (but not limited to) restraint monitoring and oxygen monitoring (although inadequate), blood sugar levels, weight, wound evaluations, food and fluid intake.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are	FA	The activities coordinator also undertakes other roles in the service including caregiving. Eight hours per week are dedicated to activities. All staff incorporate activities on a daily basis as part of their caregiving/nursing roles. A generic monthly plan is developed with resident favourites including (but not limited to) newspaper reading, housie, happy hour, outings, church services, quizzes. Interviews with residents identified that activities provided were appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. Each resident has an individual activities assessment on admission and from this information an individual activity care plan is developed. Implementation of the activities plan is evaluated monthly and attendance records are

appropriate to their needs, age, culture, and the setting of the service.		maintained. Three of four activities plans sampled had been reviewed six monthly. The respite resident did not require an activity plan and one resident had not been at the service for six months.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Care plan evaluations were sighted in three of the five resident files reviewed. One resident was on respite care and another had not been at the service for six months. These have been completed on a regular basis rather than waiting for when the six-monthly review is due. Evaluations document progress toward goals. There is at least a three-monthly review by the GP. The files reviewed included examples where changes in health status had been documented and followed up. Short-term care plans reviewed had been evaluated and closed-out, or they were added to the long-term care plan where the problem was ongoing.
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 service has a current building warrant of fitness that expires on 8 January 2019. Records and interview with the maintenance person demonstrate that the preventative maintenance plan is being implemented. This is an improvement since the previous audit. The facility is purpose-built and provides a safe and appropriate internal and external environment.
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 surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Surveillance data is available to all staff. Corrective actions are established where trends are identified. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioner. Systems in place are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint	FA	The restraint policy includes the definitions of restraint and enablers and comprehensive restraint procedures. Interviews with staff confirmed their understanding of restraints and enablers. There were no residents with

minimisation Services demonstrate that the use of restraint is actively minimised.		enablers and one resident with restraint bedrails at night. Restraint minimisation training has been provided and audits are conducted.

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	The service has a dedicated form to assess the competency of residents to self-medicate. Competency assessments have been completed but not reviewed.	The two residents that self-medicate have not had the competency assessment reviewed since June 2017.	Ensure that self-medication competencies are reviewed regularly as dictated by policy. 90 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 Moderate	The service has monitoring forms available for a variety of monitoring needs. These have not been adequately completed.	(1) Neurological observations have not been documented following unwitnessed falls or a fall with a knock to the head. (2) Monitoring forms for bedrail checks and oxygen monitoring (on and off) have not been consistently completed.	(1) Ensure monitoring forms for neurological observations are completed as required by policy. (2) Ensure oxygen

				and bedrail monitoring is documented as per care plan documentation. 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.

No data to display

End of the report.