

Rangiura Trust Board - Rangiura Rest Home & Retirement Village

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:	Rangiura Trust Board
Premises audited:	Rangiura Rest Home & Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 17 October 2019 End date: 18 October 2019
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:	74

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
Yellow	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
Red	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

Rangiura Rest Home and Retirement Village provides rest home, hospital and dementia care services for up to 76 residents. The service is owned and operated by the Rangiura Trust Board and managed by a new general manager and a clinical nurse leader, plus other people in management roles, for example, human resources, finances, food services, and housekeeping.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers and staff. The general practitioner was not available for interview, but the local nurse practitioner was interviewed on site. Residents and family spoke positively about the care provided.

Significant changes since the previous audit are the new management structure, changes in the board, and completion of building work in the main building. There have been no changes in the size or scope of services provided but there are plans to increase the size of the retirement village which may include provision of serviced apartments.

Evidence that eight of the nine previous corrective actions were resolved was confirmed. Seven new areas for improvement were identified as a result of this audit, and one more improvement related to care planning is ongoing. Areas for improvement were found in management of complaints, review and follow up actions related to adverse events, registered nurse (RN) presence in the hospital, care planning and evaluation, medicines management, food storage surfaces in the kitchen and review of the fire evacuation scheme.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Communication occurs between staff and residents and their families and with other health providers. The service adheres to the practices of open disclosure where necessary.

There had been no complaints investigated by the DHB or the Office of the Health and Disability Commissioner (HDC). Review of complaint records and interviews with staff, residents and families demonstrated that some of the complaints received since the previous audit were managed effectively.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The service is maintaining its quality and risk management system with regular monitoring of all service areas.

Adverse events are reliably reported by all levels of staff. There was evidence that people impacted by an adverse event are notified, for example, general practitioners and families. Notification of serious events is occurring as required by regulatory requirements.

Human resources systems are in place and staff are recruited and managed effectively. Staff training in relevant subject areas is occurring regularly. All staff are supported and encouraged to attend ongoing performance development and achieve educational qualifications in health care. Experienced and qualified staff are rostered on all shifts in each of the service delivery areas.

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.
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Residents' of Rangiura Rest Home have their needs assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are based on a range of information. Short term care plans are developed to manage infections. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and family members of residents interviewed reported being well informed and involved in care planning, and that the care provided is of a high standard.

The planned activity programme at Rangiura Rest Home is overseen by two diversional therapists and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by registered nurses, enrolled nurse and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents and family members of residents verified overall satisfaction with meals.

Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The facility has a current Building Warrant of Fitness. There have been changes to the footprint of the building.

Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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The systems and practices for restraint minimisation and safe practice meet the requirements of this standard. On the day of audit there were nine residents who required lap belts and bedrails for safety reasons and seven residents who used bed rails and lap belts voluntarily. Appropriate assessment, consent, approval and monitoring and review occurs in relation to the use of these interventions.

Staff training on restraint and enabler use is being provided regularly.

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.
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Rangiura Rest Home undertakes aged care specific infection surveillance with data analysed, trended and benchmarked. Results are reported through all levels of the organisation. Follow-up action is taken as and when required.

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	11	0	3	5	0	0
Criteria	0	36	0	3	5	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Moderate</p>	<p>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.</p> <p>The complaints register reviewed showed that five complaints have been received over the past year. There have been no complaint investigations by the Health and Disability Commissioner (HDC) or district health board (DHB) since the previous audit. The GM has delegated responsibility for complaints management to the nursing and administrative staff for investigation and follow up and complaint management processes were not conforming to policy, best practice, contractual or legislative requirements.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in the incident forms and residents' records reviewed. The level of written and verbal information relayed between staff at shift changes about each residents was sufficient to ensure continuity of care.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff knew how to access interpreter services, although reported this has not been</p>

environment conducive to effective communication.		required due to all residents being able to speak English.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The General Manager (GM) has been in the post for 12 months. This person has business management qualifications and had not managed a residential aged care facility prior to commencing this role. Their previous and relevant work experience is 16 years in the health sector holding executive positions in an organisation delivering palliative care services, and in the DHB Mental Health and Addictions Service which includes Mental Health Services for Older Persons, and a strategic leadership role with the local needs, assessment and coordination service (NASC).</p> <p>Responsibilities and accountabilities are defined in this person's job description and individual employment agreement. The GM was only available for the opening and closing meetings during this audit and their knowledge of the sector, regulatory and reporting requirements could not be fully ascertained. The board are kept informed verbally and in writing by the GM of all operational, quality and risk matters, confirmed by review of a sample of board meeting minutes and reports for 2018-2019.</p> <p>Rangiura Trust Board has agreements with the DHB for age related care (ARC) in rest home, dementia, and hospital (medical, geriatric care and palliative) respite/short stay and day services.</p> <p>On the day of audit 74 of the 76 beds were occupied. Thirty four residents were receiving rest home level care including two respite residents and 26 residents were receiving hospital level care. There were 14 of the 16 beds occupied by residents in the secure unit. There were no residents under the age of 65 years.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of complaints, internal audits across all areas of service delivery and monitoring of outcomes, resident and relative satisfaction surveys and the reporting and collation of adverse events such as accidents/incidents, pressure injuries, restraint interventions and infections.</p> <p>The organisation uses a sector standardised system for reporting their quality data, for example, number of falls with or without injury, medicine errors, pressure injuries, restraint, urinary tract infections, bruising and skin tears, and staff incidents. This data is collated by the nominated health and safety officer who conducts a monthly analysis looking for trends and ensuring that actions are underway to remedy any unwanted trends. Where gaps or deficits in service delivery are identified corrective actions are developed and implemented to address any shortfalls.</p> <p>Information from quality monitoring is shared with staff at regular monthly meetings and written information was observed to be on display in staff areas. The staff interviewed confirmed that they are kept well informed and may also be involved in quality and risk management processes through internal audit activities, quality projects and</p>

		<p>acting as representatives for health and safety.</p> <p>Resident and family satisfaction surveys are completed annually. Results from the most recent food satisfaction 2019 survey and interviews revealed no major issues or areas of concern.</p> <p>Policies and procedures are controlled and managed by the quality system operator to ensure a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Policies are based on best practice and cover all aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process.</p> <p>The health and safety officer who is also the HR manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. This manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. There had been no staff injuries requiring notification to Worksafe NZ.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	<p>PA Moderate</p>	<p>All adverse and near miss events are entered into an electronic system which immediately alerts the GM, clinical nurse leader and the chairperson of the trust if the level of risk is critical or major. The system collates events, into type, resident and the most common time and place which allows quick analysis for trending.</p> <p>A sample of incidents forms reviewed showed who had been notified, but not all of the records provided enough detail to clearly describe the event. Nor was there sufficient written evidence of review and investigation or follow up from incidents.</p> <p>Adverse event data is collated and presented to the health and safety committee and the health and safety reports go to the board and staff. Incident data is being benchmarked across a group of other age care provider that the organisation belongs to - Community Trusts in Care Association NZ (CTCA), and nationally with other like age care facilities.</p> <p>The HR manager is now responsible for essential notification reporting. This person interviewed understands the requirements. There have been five notifications of significant events made to the Ministry of Health, since the previous audit. Three were police investigations related to car break in's and a theft on site, resident behaviour and the appointment of the new GM in September 2018.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	<p>FA</p>	<p>Staffing policies and practices 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. The sample of seven staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>prepared them well for their role. Staff records reviewed show documentation of completed orientation followed by an initial performance review. All files sampled contained evidence that performance appraisals were up to date. The previous corrective action is closed.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. 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. Records reviewed demonstrated that 16 of the 62 health care assistants (HCAs) have completed level 4 or higher of the National Certificate in Health and Wellbeing (or its equivalent). Thirty four HCAs have achieved level 3, and 12 have achieved level 2. Interviews and documents also confirmed that 39 staff including an RN have completed the required educational achievements in dementia care (US 23920-23923). Only people with this qualification are rostered to work in the secure/dementia unit.</p> <p>Four of the seven RNs employed are maintaining annual competency requirements to undertake interRAI assessments. The full time employed physiotherapist and a long term employed enrolled nurse (EN) are also qualified to conduct interRAI with supervision and sign off by the clinical nurse leader.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Moderate</p>	<p>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 (24/7). Staffing levels are adjusted to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed.</p> <p>Six health care assistants said that unplanned staff absences meant they were often short staffed for the heavy work allocated to them. Observations, interviews with management and review of two months of the roster cycle confirmed that adequate staff cover has been provided, with staff usually replaced in any unplanned absence by bureau staff. A number of casual staff had been employed to cover absences and recruitment to build up the casual pool of healthcare assistants was ongoing.</p> <p>On the second day of audit the clinical nurse leader was the only RN on morning shift. There is usually one RN and two ENs rostered on from Monday to Friday. There was no cover or back up if the CNL was called away. Interviewees said the sole RN leaves the hospital/rest home building to attend call outs in the separate dementia unit. This is a breach of the ARC agreement and an improvement is required.</p> <p>The previous corrective action is now closed, as care staff were in the common area of the dementia unit during all site inspections, there were staff on the floor during handovers and a family member interviewed said staff were always present when they visited.</p> <p>Residents and family members were satisfied with staff cover but did say that responses to call bells were slow at times. All RNs are maintaining a current first aid certificate with CPR and there is 24 hour, seven days a week (24/7) RN coverage in the facility. Only staff who have completed educational achievements in dementia care (US</p>

		23920-23923) are rostered for duties in the secure unit.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using a manual system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications had no evidence to verify they were checked by an RN against the prescription. Eye drops in use were dated as being opened in September. Interview with the two enrolled nurses (ENs) dispensing medications, stated the eye drops should be replaced at the beginning of each month, so were outside their use by dates. This was verified by the CNL. These areas require attention. All other medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. A recent error around a controlled drug being inconsistent with controlled drug register is recorded on an incident form (refer criterion 1.2.4.3).</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the electronic medicine chart.</p> <p>There were three 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.</p> <p>Medication errors are reported to the RN and CNL and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used at Rangiora.</p>
Standard 1.3.13:	PA Low	The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people.

<p>Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>The menu follows summer and winter patterns and has been reviewed by a qualified dietitian - August-2018. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place and was registered with the South Waikato District Council in May-2019. A verification audit of the food control plan has not been undertaken as the council was advised a rebuild of the kitchen was to occur. This has now been delayed. The council has been informed and Rangiura is waiting for their verification audit.</p> <p>All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines. A previous corrective action identified the way food was stored in the chiller, required attention. Specifically around meat not being on the lower shelves, food not being covered and dated, and defrosting chicken pieces in an open bag not dated. Dry stores in the pantry had no use by dates when decanted. These required corrective actions have been addressed at this audit, however the shelves in the chiller require attention. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Residents in the secure unit have access to food items at any time.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and in residents' meetings minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were enough staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission, residents of Rangiura are initially assessed using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>Except for the respite resident's file, files reviewed verified initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changes. Interviews, documentation and observation verified the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident</p>

		<p>has increasing or changing need levels.</p> <p>The reassessment of a rest home resident with increasing needs, was evidenced to have occurred recently and within a reasonable time frame. Residents were observed to be receiving care consistent with their assessed needs. Residents who have had unwitnessed falls have neurological assessments being attended to. This finding addresses a previous corrective action that identified insufficient evidence of neurological observation being completed after unwitnessed falls, and reassessment of residents with changing needs not occurring.</p> <p>All residents have current interRAI assessments completed by six trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Plans reviewed reflected the generalised support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were reflected in the care plans reviewed.</p> <p>Care plans at times however did not evidence service integration with progress notes, activities note and medical and allied health professionals' notations. Any change in care required was documented in progress notes and verbally passed on to relevant staff, however it was not documented in either the long term or a short-term care plan. Short term care plans are used to document the specific nursing care required when a resident has an infection, however were not used to document the nursing management strategies required to manage any acute changes. Long term care plans also did not include any documentation that identified resident's additional acute needs that required attention. The previous corrective action request that identifies short term care plans not being developed in every acute situation or transferred to the long-term care plan remains in place. In addition, the staff in the secure unit did not have access to the short-term care plans in place for their residents.</p> <p>Residents and family members of residents reported participation in the development of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The NP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in handovers and verbal instructions rather than documentation (Refer 1.3.5.2). A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	<p>FA</p>	<p>The activities programme is provided by two diversional therapists (DT) and a DT assistant.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents.</p> <p>Residents in the secure unit have a 24-hour activity plan in place. This addresses a previous corrective action whereby no 24-hour activity plan was in place.</p> <p>The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included exercise sessions, housie, visiting entertainers, quiz sessions, van outings, massage, manicures, walks, 'sing a long', building projects and daily news updates.</p> <p>The activities programme is discussed at the residents' meetings and minutes indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents and family members of residents confirmed they find the programme meets their or their relative's needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations, however, are not documented by the RN in the care plan. Where progress is different from expected, the service responds by initiating changes to the care provided to the resident. Examples were sighted of short-term care plans being used for infections, however there is no documented evidence of progress being evaluated as clinically indicated. Other plans, such as wound management plans were evaluated each time the dressing was changed.</p> <p>Residents and families/whānau provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are</p>	<p>PA Low</p>	<p>A current building warrant of fitness (expiry 07 December 2019) is publicly displayed. There has been a change in the physical layout of the main building, where the community hall has been increased in size and new exits now exist. The 2015 fire evacuation scheme has not been reviewed; this is a non-conformity with the Fire and</p>

<p>provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>Emergency New Zealand (Fire Safety, Evacuation Procedures and Evacuation Schemes) Regulations 2018.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Regular inspections are carried out to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>The environment in the dementia unit is safe and appropriate for the people residing there. There was no special equipment in use, access to the kitchen was secured with a gate and the furniture and surroundings were suitable.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Observations, interviews with cleaners and inspection of cleaning trolleys and chemical storage areas, revealed that cleaning products are kept securely when not in use and that trolleys are not unattended. All cleaning staff have undertaken education in safe handling of chemicals and achieved Level 2 certificates in NZ cleaning.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance of infections at Rangiuira is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The infection control co-ordinator and CNL review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers, and externally against other aged care providers.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint system (policies and processes) and day to day practices meet the requirements of this standard. On the days of audit there were nine residents using bed rails and lap belts as restraints and seven residents using bed rails and lap belts voluntarily as enablers. Observations, records and interview with the designated restraint coordinator confirmed that assessment, consent, approval and monitoring and review occurs in relation to the use of these interventions.</p> <p>Information about restraint interventions is now included in the interRAI care plans. The sample of files (three of nine residents with restraints and two of seven using bedrails and lap belts voluntary) contained references to the restraint/enabler in place. Observations of residents with lap belts and those in bed with bed rails up and interview with the restraint coordinator confirmed that all interventions restricting freedom of movement are reviewed at frequencies determined by the extent of change in the resident or a maximum of one month as part of discussions at health and safety meetings. There was sufficient evidence to confirm that documentation about restraint intervention in care plans is now occurring and the previous area requiring improvement in criterion 2.1.1 is closed.</p> <p>Staff training on restraint and enabler use is provided regularly.</p>
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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)
<p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	<p>PA</p> <p>Moderate</p>	<p>Three of the five complaint records reviewed were lacking in documented evidence that the complaint had been acknowledged in writing, in depth investigations had occurred, what actions had been taken, or that any resolution with the complainant had occurred. Three different members of staff have been handling the complaint process since the previous audit, with some of these staff being uncertain about the processes or who was responsible for closing open complaints.</p>	<p>There is insufficient documented evidence of investigation into complaints, communication between all parties or an effective resolution. There was a lack of clarity amongst staff about their role or responsibilities regarding the complaint process.</p>	<p>Ensure that management of complaints conforms to policy, regulations, legislation and these standards.</p> <p>60 days</p>

<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Moderate</p>	<p>There was not enough detail in the descriptions of two of the twenty adverse events sampled to determine what the actual event was.</p> <p>There is insufficient recorded evidence to show that investigations occur and that where necessary, actions for improvement or to prevent recurrence are implemented.</p>	<p>Two of the twenty adverse events records sampled did not have clear descriptions of the event, and more than 50% had no evidence of review and /or investigation or that actions for improvement or to prevent recurrence had been implemented.</p>	<p>Provide evidence that adverse events are documented with sufficient detail to describe the event, that events are reviewed and where necessary investigation and follow action/s are taken to minimise risk and/or prevent recurrence.</p> <p>60 days</p>
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Moderate</p>	<p>The rosters show that one RN and one EN are rostered for evening shift and a sole RN with three HCAs for night shift. Interviews revealed that the sole RN leaves the hospital/rest home building to attend call outs in the dementia unit which is a standalone building. The organisation was not clear about the ARCC requirements for the RN to be onsite in the part of the building where hospital services are provided.D17.4. (d.iv)</p>	<p>The evening and night shift RN leaves the hospital/rest home building to attend call outs in the dementia wing. This is a breach of the ARCC requirements in D17.4.</p>	<p>Ensure there is an RN in the hospital building 24 hours a day seven days a week.</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate</p>	<p>PA Low</p>	<p>A manual system for administering medications operates at Rangiuira. Medications are dispensed by the pharmacist in blister packs. The night nurse is supposed to check the medication packs against the prescription and sign the pack. However, the present packs had no signature to verify they had been checked. Previous packs had been discarded so no evidence of past checks was sighted.</p>	<p>No evidence was sighted of reconciliation of medications each month. Eye drops are not currently</p>	<p>Provide evidence a system is in place to ensure medication management is consistent with</p>

<p>prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>The eye drops in use, were dated when opened. All were dated with the same date; however, the date was of the previous month, not the present month. The system at Rangiura, according to the CNL and the EN, is that eye drops are replaced the beginning of each month.</p> <p>The rationale for the above not occurring was the night nurse who attended to both activities was on leave.</p>	<p>monitored to ensure use by dates are adhered to.</p>	<p>guidelines.</p> <p>90 days</p>
<p>Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Low</p>	<p>Food in the chiller is stored appropriately, with expiry dates documented. The shelves however are chipped with exposed bare wood that is a challenge to keep clean and can absorb spills and contaminants.</p>	<p>The chipped surfaces of the shelves in the chiller pose an infection control risk.</p>	<p>Provide evidence that surfaces in the food service area are impervious to spills and contaminants.</p> <p>30 days</p>
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Short term care plans are used at Rangiura for residents that have infections.</p> <p>Five of seven files reviewed had no documentation in place to identify the management plan, either short or long term, for several acute events that were observed or had occurred at Rangiura. Examples include managing a resident's low blood pressure and subsequent fall, a recurrent safety risk and high risk of a resident injuring themselves, incidents of behaviours that were challenging, ongoing changes in medication or review of management strategies, a plan of care for a new respite resident who had wandered away, and a new admission with a history of chronic respiratory disease and a plan of how to manage the episodes of shortness of breath being experienced. This was discussed with the clinical nurse leader (CNL) and addressed on the day of audit, with short term care plans being put in place.</p> <p>All short-term care plans (used for residents with infections) for</p>	<p>Care plans did not describe fully the required support the resident requires to meet their assessed needs. Care staff in the secure unit do not have access to residents' short term care plans.</p>	<p>Provide evidence that care plans describe fully the required support the resident requires to meet their needs, and all care staff have access to residents' care plans.</p> <p>60 days</p>

		residents in the secure unit, are filed in the hospital/rest home office (in a separate building), to enable the RNs on duty in that area, to monitor short term care plans. Care staff working in the secure unit have no documentation in the unit that identifies the strategies required to manage the resident's infection, specific to that resident. The CNL on interview, identified staff know the residents who have infections because they are having antibiotics.		
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Moderate</p>	<p>The GP or NP reviews the residents every three months or as residents' condition requires. The physiotherapist and diversional therapists document ongoing evaluations of residents' activity needs and resident's mobility needs. Seven of seven care plans reviewed had no documentation in place to verify the RN evaluates the care the resident receives. Progress notes record changes are initiated when progress is expected; however, there was no documentation sighted that verified a formal evaluation by the RN occurs. This was verified by an interview with the CNL.</p>	<p>Evaluations of the residents' nursing care plans that occur every six months by the RN are not documented.</p>	<p>Provide evidence evaluation of care is being documented.</p> <p>60 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>Observations and interviews revealed that changes to the building (hall extension and break out rooms) has potentially impacted the previously approved 2015 evacuation scheme but review of the evacuation scheme has not occurred.</p>	<p>The 2015 evacuation scheme has not been reviewed subsequent to the changes in the main building layout.</p>	<p>Review the fire evacuation scheme, taking into account the change in the building foot-print and if required seek approval from Fire and Emergency NZ.</p> <p>90 days</p>

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, there 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.