

## **Ranfurly Manor Limited**

**CURRENT STATUS: 30-Oct-13**

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Partial provisional audit conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.**

### **GENERAL OVERVIEW**

Ranfurly Manor is one of two facilities which are privately owned by the same provider. Ranfurly Manor is changing its name to Ranfurly Residential Care Centre when it moves from its current location to a newly developed site. This audit is related to the new facility located at 6 Monmouth Street, Feilding. Current staff and residents will be making this move. This audit is undertaken to establish the level of preparedness of the provider to deliver services to meet the Health and Disability Services Standards. Residents, family/whanau and staff are kept well informed by letter, regular meetings and the facility manager's 'open door policy'.

There are three areas identified for improvement. These relate to the service awaiting the approved evacuation plan; gaining a certificate of public use for the building; and the completion of the flooring.

# **Ranfurly Manor**

Ranfurly Manor Limited

Partial provisional audit - Audit Report

Audit Date: 30-Oct-13



## Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXXXXX	RCN, BA, Lead Auditor 8086	6	4	30-Oct-13
Auditor 1					
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXXXXX	RN, MBA, NZQA 8086		1	

<b>Total Audit Hours on site</b>	6	<b>Total Audit Hours off site</b> <i>(system generated)</i>	5	<b>Total Audit Hours</b>	11
<b>Staff Records Reviewed</b>	6 of 46	<b>Client Records Reviewed</b> <i>(numeric)</i>	5 of 50	<b>Number of Client Records Reviewed using Tracer Methodology</b>	0 of 5
<b>Staff Interviewed</b>	11 of 46	<b>Management Interviewed</b> <i>(numeric)</i>	2 of 2	<b>Relatives Interviewed</b> <i>(numeric)</i>	4

<b>Consumers Interviewed</b>	6 of 50	<b>Number of Medication Records Reviewed</b>	14 of 50	<b>GP's Interviewed (aged residential care and residential disability) (numeric)</b>	0
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## Declaration

I, (full name of agent or employee of the company) XXXXXXXXXX (occupation) Managing Director of (place) Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 13th day of November 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit:

The audit summary has been developed in consultation with the provider:

Electronic Sign Off from a DAA delegated authority (*click here*):

## Services and Capacity

Premise Name	Total Number of Beds	Number of Beds Occupied on Day of Audit	Number of Swing Beds for Aged Residential Care	Kinds of services certified												
				Hospital Care							Rest Home Care		Residential Disability Care			
				Children's Health Services	Geriatric Services (excluding dedicated Psychogeriatric Unit)	Geriatric Services-Psychogeriatric	Maternity Services	Medical Services	Mental Health Services	Surgical Services	Rest Home (excluding dedicated Dementia Care)	Dedicated Dementia Care	Intellectual Disability	Physical Disability	Psychiatric Disability	Sensory Disability
Ranfurly Manor	114	0	93	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# Executive Summary of Audit

## *General Overview*

Ranfurly Manor is one of two facilities which are privately owned by the same provider. Ranfurly Manor is changing its name to Ranfurly Residential Care Centre when it moves from its current location to a newly developed site. This audit is related to the new facility located at 6 Monmouth Street, Feilding. Current staff and residents will be making this move. This audit is undertaken to establish the level of preparedness of the provider to deliver services to meet the Health and Disability Services Standards. Residents, family/whanau and staff are kept well informed by letter, regular meetings and the facility manager's 'open door policy'.

There are three areas identified for improvement. These relate to the service awaiting the approved evacuation plan; gaining a certificate of public use for the building; and the completion of the flooring.

### *1.1 Consumer Rights*

Not applicable to this audit

### *1.2 Organisational Management*

The facility manager has the authority to oversee all aspects of service delivery. She is very experienced in age care management, and along with the owner, services are planned to meet all residents' needs. The new building construction is overseen by a project manager and the facility manager works closely with the construction team to ensure all equipment and services are in place to meet service delivery requirements.

During the absence of the facility manager the clinical nurse leader and the administration manager undertake the role. This has occurred via succession planning and works well for the organisation.

Human resource management processes are conducted by the organisation to reflect good employment practice and meet legislative requirements. Job descriptions identify each role's authority, accountability and responsibility. There is a comprehensive orientation process implemented and staff education is well documented. This includes specific education to be put in place related to emergency management, new equipment and security training, related to having CCTV (closed circuit television) cameras at the new facility.

The service implements safe staffing levels and skill mixes that are clearly set out in policy. The service is taking all existing staff across to the new site and the facility manager has completed a tentative new roster which identifies how the staff numbers will be increased to meet the intake of new residents, once the move to the new building has been undertaken. This includes ensuring a RN is on duty at all times, and that when the secure dementia unit is in operation, that only staff with required qualifications will work in the area. Staff are kept fully informed of the progress of the build and a letter has been sent to all staff calling for expressions of interest for staff who hold appropriate qualifications and who would like to work into the secure dementia unit when it opens.

### *1.3 Continuum of Service Delivery*

Resident care evaluation is undertaken at least six monthly or sooner if there is a change in the resident's condition. All evaluations sighted are up to date. This was an area identified for improvement in the previous audit which is now met.

Food services are implemented to meet policy requirements and meals are prepared to meet dietitian approved menus. An interview with the cook confirms that the service can cater for all levels of dietary requirements. The new facility is very well equipped.

Medication management and administration practices meet current legislative, regulatory and safe practice guidelines and are appropriate for services provided. Staff have received training and are knowledgeable in their roles in relation to medicine management. There are secure storage areas and medicine trolleys available in the new building.

#### *1.4 Safe and Appropriate Environment*

Emergency planning, policies and processes are in place to ensure residents, visitors and staff are protected from harm as a result of exposure to waste or infectious substances generated during service delivery. The new building has appropriate storage for chemicals and sharps.

The new laundry has adequate equipment and a good clean dirty flow to meet good infection control standards. Staff education is planned for November 2013 to ensure laundry staff understand and use the newly purchased laundry equipment.

The facilities are fit for purpose and provide an appropriate, accessible physical environment for residents. There are adequate toilet and showering facilities. With the exception of four, two bedroom apartments, all bedrooms are single occupancy and spacious, to allow hospital aid equipment to be used as required. The dining and lounge areas meet residents' relaxation, activity and dining needs. The facility has under floor central heating and a clean air ceiling ventilation system.

There are newly developed outdoor areas that have seating and sheltered areas for resident use. The facility and the grounds are smoke free.

Emergency and security responses are well documented. Six monthly fire evacuations and emergency education is undertaken. There are adequate supplies, including food, water and access to utilities for use in an emergency.

Areas for improvement relate to the new building not yet having an approved fire evacuation plan. This has been filed with the Fire Service. There is no signed off code of completion for the building and all the flooring is yet to be completed.

## *2 Restraint Minimisation and Safe Practice*

Not applicable to this audit.

## *3. Infection Prevention and Control*

Infection control management systems are implemented by the service as documented in policy to minimise the risk of infection to consumers, service providers and visitors. The service has an up to date infection control programme which is reviewed at senior management level annually.

## Summary of Attainment

### 1.1 Consumer Rights

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.1.1	Consumer rights during service delivery	Not Applicable	0	0	0	0	0	1
Standard 1.1.2	Consumer rights during service delivery	Not Applicable	0	0	0	0	0	4
Standard 1.1.3	Independence, personal privacy, dignity and respect	Not Applicable	0	0	0	0	0	7
Standard 1.1.4	Recognition of Māori values and beliefs	Not Applicable	0	0	0	0	0	7
Standard 1.1.6	Recognition and respect of the individual's culture, values, and beliefs	Not Applicable	0	0	0	0	0	2
Standard 1.1.7	Discrimination	Not Applicable	0	0	0	0	0	5
Standard 1.1.8	Good practice	Not Applicable	0	0	0	0	0	1
Standard 1.1.9	Communication	Not Applicable	0	0	0	0	0	4
Standard 1.1.10	Informed consent	Not Applicable	0	0	0	0	0	9
Standard 1.1.11	Advocacy and support	Not Applicable	0	0	0	0	0	3
Standard 1.1.12	Links with family/whānau and other community resources	Not Applicable	0	0	0	0	0	2
Standard 1.1.13	Complaints management	Not Applicable	0	0	0	0	0	3

Consumer Rights Standards (of 12):	N/A:12	CI:0	FA: 0	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0	PA Crit: 0
	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0			
Criteria (of 48):	CI:0	FA:0	PA:0	UA:0	NA: 0			

## 1.2 Organisational Management

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.2.1	Governance	FA	0	1	0	0	1	3
Standard 1.2.2	Service Management	FA	0	1	0	0	0	2
Standard 1.2.3	Quality and Risk Management Systems	Not Applicable	0	0	0	0	0	9
Standard 1.2.4	Adverse event reporting	Not Applicable	0	0	0	0	0	4
Standard 1.2.7	Human resource management	FA	0	4	0	0	0	5
Standard 1.2.8	Service provider availability	FA	0	1	0	0	0	1
Standard 1.2.9	Consumer information management systems	Not Applicable	0	0	0	0	0	10

Organisational Management Standards (of 7):	N/A:3	CI:0	FA: 4	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 34):	CI:0	FA:7	PA:0	UA:0	NA: 1		

### 1.3 Continuum of Service Delivery

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.3.1	Entry to services	Not Applicable	0	0	0	0	0	5
Standard 1.3.2	Declining referral/entry to services	Not Applicable	0	0	0	0	0	2
Standard 1.3.3	Service provision requirements	Not Applicable	0	0	0	0	0	6
Standard 1.3.4	Assessment	Not Applicable	0	0	0	0	0	5
Standard 1.3.5	Planning	Not Applicable	0	0	0	0	0	5
Standard 1.3.6	Service delivery / interventions	Not Applicable	0	0	0	0	0	5
Standard 1.3.7	Planned activities	Not Applicable	0	0	0	0	0	3
Standard 1.3.8	Evaluation	FA	0	1	0	0	1	4
Standard 1.3.9	Referral to other health and disability services (internal and external)	Not Applicable	0	0	0	0	0	2
Standard 1.3.10	Transition, exit, discharge, or transfer	Not Applicable	0	0	0	0	0	2
Standard 1.3.12	Medicine management	FA	0	4	0	0	0	7
Standard 1.3.13	Nutrition, safe food, and fluid management	FA	0	3	0	0	0	5

Continuum of Service Delivery Standards (of 12):	N/A:9	CI:0	FA: 3	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 51):	CI:0	FA:8	PA:0	UA:0	NA: 1		

#### 1.4 Safe and Appropriate Environment

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.4.1	Management of waste and hazardous substances	FA	0	2	0	0	0	6
Standard 1.4.2	Facility specifications	PA Low	0	1	2	0	0	7
Standard 1.4.3	Toilet, shower, and bathing facilities	FA	0	1	0	0	0	5
Standard 1.4.4	Personal space/bed areas	FA	0	1	0	0	0	2
Standard 1.4.5	Communal areas for entertainment, recreation, and dining	FA	0	1	0	0	0	3
Standard 1.4.6	Cleaning and laundry services	FA	0	2	0	0	0	3
Standard 1.4.7	Essential, emergency, and security systems	PA Low	0	4	1	0	0	7
Standard 1.4.8	Natural light, ventilation, and heating	FA	0	2	0	0	0	3

Safe and Appropriate Environment Standards (of 8):	N/A:0	CI:0	FA: 6	PA Neg: 0	PA Low: 2	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 36):	CI:0	FA:14	PA:3	UA:0	NA: 0		

## 2 Restraint Minimisation and Safe Practice

		Attainment	CI	FA	PA	UA	NA	of
Standard 2.1.1	Restraint minimisation	Not Applicable	0	0	0	0	0	6
Standard 2.2.1	Restraint approval and processes	Not Applicable	0	0	0	0	0	3
Standard 2.2.2	Assessment	Not Applicable	0	0	0	0	0	2
Standard 2.2.3	Safe restraint use	Not Applicable	0	0	0	0	0	6
Standard 2.2.4	Evaluation	Not Applicable	0	0	0	0	0	3
Standard 2.2.5	Restraint monitoring and quality review	Not Applicable	0	0	0	0	0	1

Restraint Minimisation and Safe Practice Standards (of 6):	N/A: 6	CI:0	FA: 0	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 21):	CI:0	FA:0	PA:0	UA:0	NA: 0		

### 3 Infection Prevention and Control

		Attainment	CI	FA	PA	UA	NA	of
Standard 3.1	Infection control management	FA	0	3	0	0	0	9
Standard 3.2	Implementing the infection control programme	Not Applicable	0	0	0	0	0	4
Standard 3.3	Policies and procedures	Not Applicable	0	0	0	0	0	3
Standard 3.4	Education	Not Applicable	0	0	0	0	0	5
Standard 3.5	Surveillance	Not Applicable	0	0	0	0	0	8

Infection Prevention and Control Standards (of 5): N/A: 4 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0  
 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0

Criteria (of 29): CI:0 FA:3 PA:0 UA:0 NA: 0

**Total Standards (of 50)** N/A: 34 CI: 0 FA: 14 PA Neg: 0 PA Low: 2 PA Mod: 0 PA High: 0 PA Crit: 0 UA  
 Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  
**Total Criteria (of 219)** CI: 0 FA: 32 PA: 3 UA: 0 N/A: 2

## Corrective Action Requests (CAR) Report

Provider Name: Ranfurly Manor Limited  
 Type of Audit: Partial provisional audit

Date(s) of Audit Report: Start Date:30-Oct-13 End Date: 30-Oct-13  
 DAA: The DAA Group Limited  
 Lead Auditor: XXXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.4.2	1.4.2.1	PA Low	<p><b>Finding:</b> The new build does not yet have a certificate of public use. This is a legislative requirement.</p> <p><b>Action:</b> Ensure the certificate of public use for the build is sighted before the building can be occupied.</p>	Prior to occupation.
1.4.2	1.4.2.4	PA Low	<p><b>Finding:</b> Not all the flooring was completed on the day of audit.</p> <p><b>Action:</b> Ensure all flooring is completed and secure.</p>	Prior to occupation
1.4.7	1.4.7.3	PA Low	<p><b>Finding:</b> The service is awaiting approval for the fire evacuation plan.</p> <p><b>Action:</b> Ensure all processes are met to gain an approved evacuation plan.</p>	Six months

## Continuous Improvement (CI) Report

Provider Name: Ranfurly Manor Limited  
Type of Audit: Partial provisional audit

Date(s) of Audit Report: Start Date:30-Oct-13 End Date: 30-Oct-13  
DAA: The DAA Group Limited  
Lead Auditor: XXXXXXXXX

# 1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

## OUTCOME 1.2 ORGANISATIONAL MANAGEMENT

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

### STANDARD 1.2.1 Governance

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Evaluation methods used: D  SI  STI  MI  CI  Ma  V  CQ  SQ  STQ  Ma  L

#### How is achievement of this standard met or not met?

**Attainment: FA**

The facility manager is a registered nurse. She has been working at the existing facility as the manager for five years and has over 15 years management experience in all areas of health care. She holds a Post Graduate Diploma in Nursing from Massey University and is enrolled in the MidCentral District Health Board (MCDHB) professional development recognition programme to maintain the requirements of her nursing registration. She undertakes both in-house and off-site education relevant to her role. The facility manager has a certificate in human resource management; she attends the MidCentral District Health Board Hub meetings which cover management topics, such as enduring power of attorney management and community service resources. She is currently attending the Hospice Palliative Care programme. Her job description sighted identifies that she has the authority, accountability and responsibility for the provision of services offered at Ranfurly Manor. She also has the authority to prepare all clinical oversight for the shift to the new building.

The new building construction is overseen by a project manager. The project manager, the owner and the facility manager work closely together to ensure services are appropriate for aged care residents.

The service has a full report on dementia care which outlines best practice standards and thinking, and this document has allowed them in their planning to develop a philosophy of care model which is resident focused. The facility manager, with the assistance of a Doctor of Nursing, are in the process of updating policies and procedures to reflect the newly accepted model of care to incorporate dementia care services.

Interviews with six of six residents and four of four family/whanau members confirm they are happy with the level of care offered and that they have been kept fully informed of the upcoming shift to the new building. All residents and family/whanau have been given the opportunity to voice any concerns both verbally and in writing, and all questions have been answered honestly and promptly by the facility manager. The shifting day procedures have been fully explained, including transport and food services. Relatives and residents have been reminded to put a change of address form so that their insurance company, telephone provider and television provider are aware.

**Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

### **STANDARD 1.2.2 Service Management**

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Evaluation methods used: D  SI  STI  MI  CI  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

The clinical nurse leader's job description identifies that she will take the role of the facility manager in relation to the clinical care as required. She is assisted by the administration manager who looks after the non-clinical side of the business. This has occurred via succession planning and works well for the organisation.

**Criterion 1.2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

### **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.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Evaluation methods used: D  SI  STI  MI  CI  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

Policies and procedure are implemented during the employment process. They reflect current good human resource practices and meet legislative requirements. Professional qualifications are validated for staff that require them. Annual practising certificates are sighted for 12 RNs (3 are casual staff), two ENs, the GP service and the pharmacy. These are monitored by the administration manager and a reminder is sent one month prior to the next due date. All staff have police and referee checks undertaken.

Currently there are 12 RNs, two ENs and 32 caregivers employed by the service. One of the ENs is a Careerforce assessor and records sighted show that 12 caregivers have completed Careerforce qualifications including the dementia series, two caregivers have just the dementia series and six staff have completed the core Careerforce papers.

The existing staff are transferring to the new premises and the facility manager will advertise and employ more staff as bed numbers increase. The facility already uses casual and part time staff and many staff have indicated they would like to increase their hours if possible. This was confirmed during staff interviews. The facility manager states that they have a very low staff turnover and that there are a lot of people who are on a waiting list for jobs.

The facility manager is aware that for the new facility, staff who wish to work in the secure dementia care unit must either hold a recognised dementia care qualification or be actively working towards gaining a qualification. The facility manager confirms that new staff will have six months to complete the papers and that there will always be a dedicated staff member rostered on the dementia care unit who holds the appropriate qualification. It is intended to be a 26 bed unit when completely full, but for the purpose of this audit, the service only intends to open 20 dementia care beds early in the 2014 year. The service understands that these may take a while to fill but that it is required to have dedicated staff in the unit regardless of the number of residents.

Staff education is appropriate to the role staff undertake, as confirmed in six staff file reviews (one RN, one EN, one cleaner, two caregivers and the facility manager). Staff undertake a full induction process which is appropriate to the role they are employed to for. There is a specific clinical staff induction and the service has approved preceptors. Staff appraisals are up to date in the six staff file reviews undertaken. There is an electronic process in place to identify when appraisals are due. There is an annual education calendar which identifies in-service and off-site training for staff. Staff interviews confirm the education they receive is adequate and appropriate to deliver services in age care. Each individual staff member has documented education attendance.

A letter to staff explains that the intake of new residents will be a staggered admission process so that staffing numbers can be increased as required to meet service demand. All 11 of 11 staff interviewed are very happy with the information they have been given and are looking forward to the move.

Interviews with six of six residents and four of four family/whanau members confirm that services are delivered to meet their needs and that staff are professional in their approach.

**Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Evaluation methods used: D  SI  STI  MI  CI  Ma  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

The service has a clearly documented and implemented process to determine required service provider levels and skill mixes to meet residents' needs. All shifts are covered by at least one registered nurse. All 12 RNs hold level four cardiopulmonary resuscitation and caregivers hold level two first aid certificates.

The current rosters sighted for a six week period identifies that staff sickness and annual leave is replaced appropriately. Initially all the existing residents will be transferred to the new building so staffing levels will remain the same. The facility manager stated that staff numbers will be increased as required to meet the increase of residents. There is a tentative projected roster available.

The new facility will be operated as three wings of 25 residents. The current facility operates as two wings of 25 residents. The existing staffing levels for each wing will be replicated as this skill mix and staffing numbers has proven to be appropriate for the service. Staff are kept fully informed of the progress of the build and a letter has been sent to all staff calling for expressions of interest for staff that hold appropriate qualifications who would like to go into the secure dementia unit when it opens. This is confirmed during 11 of 11 staff interviews and in documentation sighted.

The current roster identifies that the CNL and facility manager work Monday to Friday.

Morning duties have:

- two RNs or one RN and one EN
- two caregivers work 8 hours and six caregivers work 6 hours starting at varying times.

Afternoon duties have:

- two RNs
- two caregivers for 8 hours, one caregiver for 7 hours, three caregivers for 5 hours and two caregivers for 4 hours.

Night duties have:

- one RN
- two caregivers for 8 hours.

The secure dementia care unit will be staffed by appropriately trained staff who will work four days on and two days off. There will also be a change to night duty to ensure there are always two RNs on duty at the facility. One will be dedicated to the attached apartments and the secure dementia unit.

**Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

### **OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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.

#### **STANDARD 1.3.8 Evaluation**

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Evaluation methods used: D  SI  STI  MI  CI  Ma  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

An area identified for improvement in the previous audit is now met. Documentation of evaluations identifies that evaluations are undertaken six monthly. Discussions with two RNs and a review of five files (four hospital and one rest home) identifies that evaluation timelines are being met. All evaluations are current. Staff evaluations of resident goals are shown. This could be better resident focused in some cases but discussions with the facility manager identify that staff are undertaking ongoing education in this area. Interviews with six of six residents and four of four family/whanau members confirms all their needs and wants are met by the service.

**Criterion 1.3.8.2 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.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

#### **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.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i.i.2; D18.2; D19.2d

Evaluation methods used: D  SI  STI  MI  CI  Mal  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

The service implements a medicines management system to ensure residents receive medicines in a safe and timely manner that complies with current legislative requirements and is reflective of safe practice guidelines. A review of 14 medicine files confirm that all medications are prescribed by a medical practitioner, they are dispensed in Douglas medico blister packs, administered by either RNs or ENs who are deemed as competent. RNs have completed a syringe driver competency via the local hospice as the service also manages palliative care residents as required. The GPs three monthly medication reviews are well documented. Medicines are stored in a locked trolley which is kept in a secure room and controlled medications are correctly stored.

The purchase of new safes for the storage of controlled medicines at the new facility is sighted. Medication reconciliation is undertaken by staff monthly upon delivery of each new batch of medicines. The pharmacy will only dispense medicines that are charted by the GP.

Policies and procedures identify that residents can self-medicate and the actions to be undertaken by staff if this occurs. At the time of audit there are no residents who are self-medicating.

The new building has a dedicated medication area in the dementia unit and the main facility which are secured.

**Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

Timeframe:

**Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Evaluation methods used: D  SI  STI  MI  CI  Ma  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

The service has an approved menu which was signed off by a registered dietitian in August 2012 to say it is suitable for the aged care services offered. The menus are currently under a further review by a dietitian to ensure they will also be suitable for residents in a secure dementia unit.

Resident's likes and dislikes are ascertained upon admission during a nutritional assessment which is conducted by a RN. This is confirmed in five of five resident file reviews.

All kitchen staff have completed safe food handling education and the cook has gained a recognised paper (167) in food safety. The head cook confirms that all residents' needs can be met by the service. She has had input into the type and placement of equipment in the kitchen in the new unit. She stated that there is enough equipment, including hot boxes, to cater for the additional service delivery in the secure dementia care unit.

New equipment sighted at the new facility includes dishwasher, combi-oven, dry pantry storage, bain-marie, gas cooking hobs, a walk-in chiller and a separate walk-in freezer, both with electronic temperature recordings. The hot box sighted will be used to deliver food to the secure dementia unit. The menu planning is to include a rolling breakfast time from 7.30 to 10 am so residents can eat breakfast at a time suitable to them.

The current services conform with all aspects of food procurement, production, preparation and storage. The head cook and the facility manager confirm that kitchen services will continue to meet residents' needs and wants in the new building.

Interviews with six of six residents and four of four family/whanau members confirm that they enjoy the food and that their likes and dislikes are catered for.

**Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

#### **OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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. These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

#### **STANDARD 1.4.1 Management Of Waste And Hazardous Substances**

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Evaluation methods used: D  SI  STI  MI  CI  MaI  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

There is a clearly documented policy and procedures for the safe and appropriate storage and disposal of waste. They meet infection control requirements. There are no specific territorial authority requirements. Sharps are disposed of in specific sharps bins. These will be located in secured areas in the new building. Chemical storage rooms in the new building are securely locked. Safety data sheets will be available in all areas where chemicals are stored.

Personal protective equipment/clothing (PPE) sighted, includes disposable gloves and aprons, goggles and masks. Interviews with 11 of 11 staff from across the organisation (caregivers, RNs, EN, cleaning, maintenance, laundry and management) confirm they can access PPE at any time and they can verbalise appropriate use. Staff are observed wearing disposal gloves and aprons as required. The facility manager confirms this will continue to be the case in the new building.

**Criterion 1.4.1.1** Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**Criterion 1.4.1.6** Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

### **STANDARD 1.4.2 Facility Specifications**

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Evaluation methods used: D  SI  STI  MI  CI  Mal  V  CQ  SQ  STQ  Ma  L

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: PA Low</b>
All processes are undertaken as required to maintain the service building warrant of fitness. The new building has not yet gained a public use certificate and this process is being managed by a local construction company who have a project manager overseeing the build. The site plan approval is visible. The expected completion date is 29 November 2013. As is required all building contractors must ensure their work standard is maintained and overseen for at least 12 months post completion date. The building consent number is 122369.	

All biomedical and medical equipment which includes beds, hoists, oxygen connectors and regulators, sphygmomanometers, stethoscopes, syringe drivers and weigh scales both sit on and hoist have been checked within the last 12 months (December 2012). This service is contracted to an approved provider. Electrical safety checks have been undertaken. All new equipment purchased for the new building have been obtained from appropriate providers and the facility manager will ensure all guarantees and warranties are filed and instructions are followed.

Whilst the new building was not fully completed at the time of audit, it has wide corridors with secure handrails. The flooring was being completed on the day of audit and will be secure in all areas. Non carpeted areas are non-slip vinyl. All bedrooms have wide door openings to allow for easy movement of beds if required. There are built in linen cupboards to prevent clutter.

The secure dementia unit has a keypad door lock. There is quiet room for resident or family/whanau use.

Residents who have mobility difficulties are assessed by a physiotherapist and appropriate walking aids are obtained to assist with safe mobilisation.

Residents have access to outdoor areas with seating and shaded areas. The outdoor areas have planted started.

**Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.**

**Audit Evidence**

**Attainment: PA**

**Risk level for PA/UA: Low**

The new building does not yet have a certificate of public use. This is required prior to the code of compliance being issued. This build is being done in two stages, so initially are required to have a certificate of public use from the council. The facility manager is aware that this must be notified to the Ministry of Health before approval to occupy the building can be obtained.

**Finding Statement**

The new build does not yet have a certificate of public use. This is a legislative requirement.

**Corrective Action Required:**

Ensure the certificate of public use for the build is sighted before the building can be occupied.

**Timeframe:**

Prior to occupation.

**Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.**

**Audit Evidence**

**Attainment: PA**

**Risk level for PA/UA: Low**

Not all the flooring was completed on the day of audit. The flooring that was completed was secure and areas not carpeted have non-slip surfaces.

**Finding Statement**

Not all the flooring was completed on the day of audit.

**Corrective Action Required:**

Ensure all flooring is completed and secure.

**Timeframe:**

Prior to occupation

**Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.**

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities**

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

Evaluation methods used: D  SI  STI  MI  CI  MaI  V  CQ  SQ  STQ  Ma  L

<b>How is achievement of this standard met or not met?</b>	<b>Attainment: FA</b>
The new building has a gas reticulation water unit which allows the hot water temperature to be set at the required 45oC maximum for all resident areas. The hot water temperatures are currently checked and recorded monthly and this will continue in the new unit.	
With the exception of one bedroom located in the secure dementia care unit, all bedrooms have ensuite units. There are adequate toilet and showers centrally located consisting of 11 showers in the hospital/rest home area and three in the secure dementia care unit. Fixtures and fittings are of good quality and there are emergency call bells and stainless steel grab rails in all bathroom areas. There are locks on the all doors to ensure privacy when undertaking personal cares. There are separate staff and visitor toilets.	

**Criterion 1.4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.**

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		

Timeframe:

**STANDARD 1.4.4 Personal Space/Bed Areas**

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Evaluation methods used: D  SI  STI  MI  CI  MaI  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

With the exception of four two bedroom apartments all bedrooms are single occupancy. It is well documented that residents can personalise their bedrooms as they are in the existing facility. A letter sent to all family/whanau members invites them to visit the new facility prior to the opening and asking them if they would like to assist in the preparation of their relative's bedroom. Bedrooms are large enough to allow residents with or without mobility aids to move around safely.

The bedrooms in the secure dementia unit have different coloured doors for ease of identification.

All bedrooms have matching built in wardrobe and drawer units. There are 48 bedrooms with ranch sliders that allow direct outdoor access.

There are 13 bedrooms with ceiling hoists and two bedrooms has ceiling hoists which allow direct transfer of the resident into the bathroom area.

**Criterion 1.4.4.1 Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely manoeuvre with the assistance of their aid within their personal space/bed area.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining**

Consumers are provided with safe, adequate, age-appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Evaluation methods used: D  SI  STI  MI  CI  MaI  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

There is a large centralised lounge/dining area which will be divided with furnishings. There is easy access from this area to a centralised courtyard area. There are also two smaller lounges for resident use. The secure dementia unit has its own dining/lounge area with a kitchenette that can be locked off when not in use.

The whole building is wired for Wi-Fi technology so that computers can be used from all areas of the building. The lounge areas can also be used for activities. There is a specific activities area which also leads to the outdoor garden which has a large gazebo. There is a purpose built hairdressing room.

The building has dedicated storage space for wheelchairs and storage to prevent clutter. There is a staff room with a meeting/education room which can be divided off at one end.

Each wing has its own nurses' station which is centrally located.

**Criterion 1.4.5.1 Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.6 Cleaning And Laundry Services**

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Evaluation methods used: D  SI  STI  MI  CI  Ma  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

Cleaning and laundry processes are described in policy. There are dedicated cleaning and laundry staff, seven days a week. Interviews with cleaning and laundry staff confirm their understanding of the use of personal protective equipment and they verbalised their knowledge related to when to wear gloves and aprons.

Chemicals supplied have up to date safety data sheets available. There are two new commercial washing machines and two new industrial dryers in the new building laundry area. There is also a large drying room at one end of the laundry which has a good clean and dirty flow. Education is planned for November for laundry staff. This will be provided by the suppliers of the new equipment.

The cleaning trolleys will be stored in secure sluice rooms in each wing of the facility. There is a central vacuum system which has outlets on both sides of each corridor to prevent the hoses running across walking space areas. Monthly cleaning and laundry audits will be maintained by the service to ensure processes undertaken are effective.

Interviews with residents and family/whanau confirm they are satisfied with current laundry and cleaning services.

**Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.7 Essential, Emergency, And Security Systems**

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

Evaluation methods used: D  SI  STI  MI  CI  MaI  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: PA Low**

The service has applied for Fire Service approval of the evacuation plan as sighted. This has not been received at the time of audit.

The whole facility has hard wired smoke and heat detectors and there is a sprinkler system throughout. The systems will be maintained by an approved provider to meet regulatory requirements. The facility manager stated that a trial evacuation will be conducted by staff prior to the shift. Fire evacuation drills are performed at least six monthly as identified in documentation sighted. This practice will continue in the new building.

There is a covered walkway to the main entrance which is wide enough for hospital gurneys or a bed if required. There is emergency lighting to meet building regulations and warrant of fitness requirements.

Civil defence and emergency supplies, which are checked regularly, will be taken to the new building. All clinical staff hold current first aid certificates to ensure there is always a staff member on duty in case of an emergency.

Staff are required to ensure doors and windows are securely closed at night and this will continue to be undertaken in the new building. The new facility is fitted with CCTV cameras and monitoring of this will be explained to staff as part of pre-shift education to be conducted.

Call bells are sighted in all resident areas. They are connected to a LED ceiling display.

**Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.**

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
<b>Corrective Action Required:</b>		
<b>Timeframe:</b>		

**Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.**

<b>Audit Evidence</b>	<b>Attainment: PA</b>	<b>Risk level for PA/UA: Low</b>
The application for the fire evacuation plan has been filed with the Fire Service on the 5 September 2013.		
<b>Finding Statement</b>		
The service is awaiting approval for the fire evacuation plan.		
<b>Corrective Action Required:</b>		
Ensure all processes are met to gain an approved evacuation plan.		
<b>Timeframe:</b>		
Six months		

**Criterion 1.4.7.4** Alternative energy and utility sources are available in the event of the main supplies failing.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
Corrective Action Required:		
Timeframe:		

**Criterion 1.4.7.5** An appropriate 'call system' is available to summon assistance when required.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
Corrective Action Required:		
Timeframe:		

**Criterion 1.4.7.6** The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

<b>Audit Evidence</b>	<b>Attainment: FA</b>	<b>Risk level for PA/UA:</b>
<b>Finding Statement</b>		
Corrective Action Required:		
Timeframe:		

**STANDARD 1.4.8 Natural Light, Ventilation, And Heating**

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Evaluation methods used: D  SI  STI  MI  CI  MaI  V  CQ  SQ  STQ  Ma  L

**How is achievement of this standard met or not met?**

**Attainment: FA**

All resident areas have at least one opening window and/or door which provides natural light and ventilation. There is also a ceiling fresh air system throughout the building. The facility is centrally heated via under floor heating which is thermostatically controlled.

The facility manager stated the service has run a very successful stop smoking programme for staff as the new building and grounds will be smoke free.

**Criterion 1.4.8.1 Areas used by consumers and service providers are ventilated and heated appropriately.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.8.2 All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

### 3. HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

#### STANDARD 3.1 Infection control management

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D  SI  STI  MI  CI  Mal  V  CQ  SQ  STQ  Ma  L

#### How is achievement of this standard met or not met?

**Attainment: FA**

The responsibility for infection control is clearly defined in the job description sighted for the clinical nurse leader who is the nominated infection control coordinator. It identifies lines of accountability for infection control matters which must be reported to the facility manager and the owner as appropriate. The facility manager completes an infection control report monthly and presents it to the owner/director so that he is aware of all issues that arise.

The service has a full suite of infection control policies and procedures along with an infection control programme which is reviewed at least annually. All data collected is trended and benchmarked against previously collected data and is used to lower the infection rate as required. Data is collected for urinary tract infections, soft tissue and wounds, eye infections and diarrhoeal conditions. This information is shared with staff and management.

As in the current facility, the new building will have hand sanitiser available at the entrance and throughout the building for staff and visitor use. There are appropriate notices asking visitors not to enter if they are unwell.

**Criterion 3.1.1 The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

Corrective Action Required:

Timeframe:

**Criterion 3.1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.**

**Audit Evidence**

**Attainment: FA**

**Risk level for PA/UA:**

**Finding Statement**

Corrective Action Required:

Timeframe: