

# Ranfurly Manor Limited

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Current Status: 7 August 2014

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

## General overview

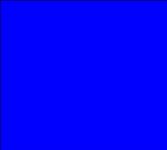
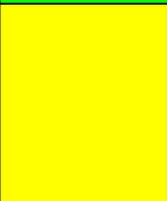
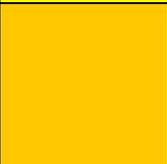
Ranfurly Manor Ltd is a privately owned company which operates Ranfurly Residential Care Centre. A new purpose built facility has been built and opened in Feilding, which has increased the size of Ranfurly Residential Care Centre to 113 beds. This includes a 20 bed dementia unit which on the first day of audit was occupied by eight residents. The new building has individual rooms for residents requiring hospital and rest home level care; and residential care suites which are occupied under license to occupy agreements by people who are assessed as requiring rest home or hospital level care.

One area for improvement is identified at this spot surveillance audit. This relates to the food provided which residents report is unappealing and bland and does not meet their needs for appetizing meals.

## Audit Summary as at 7 August 2014

Standards have been assessed and summarised below:

### Key

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

### **Consumer Rights as at 7 August 2014**

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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### **Organisational Management as at 7 August 2014**

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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### **Continuum of Service Delivery as at 7 August 2014**

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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### **Safe and Appropriate Environment as at 7 August 2014**

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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### **Restraint Minimisation and Safe Practice as at 7 August 2014**

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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### **Infection Prevention and Control as at 7 August 2014**

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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# HealthCERT Aged Residential Care Audit Report (version 4.0)

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## Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under 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).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## Audit Report

<b>Legal entity name:</b>	Ranfurly Manor Limited		
<b>Certificate name:</b>	Ranfurly Manor Limited		
<b>Designated Auditing Agency:</b>	The DAA Group Limited		
<b>Types of audit:</b>	Surveillance Audit		
<b>Premises audited:</b>	Ranfurly Residential Care Centre		
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)		
<b>Dates of audit:</b>	<b>Start date:</b> 7 August 2014	<b>End date:</b> 8 August 2014	
<b>Proposed changes to current services (if any):</b>			
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			90

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	14	<b>Hours off site</b>	4
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	14	<b>Total hours off site</b>	6
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	28	Total audit hours off site	12	Total audit hours	40
Number of residents interviewed	9	Number of staff interviewed	14	Number of managers interviewed	4
Number of residents' records reviewed	14	Number of staff records reviewed	7	Total number of managers (headcount)	5
Number of medication records reviewed	28	Total number of staff (headcount)	105	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

## Declaration

I, XXXXX, Director of 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:

a)	I am a delegated authority of The DAA Group Limited	Yes
b)	The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	The DAA Group Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	The DAA Group Limited has provided all the information that is relevant to the audit	Yes
h)	The DAA Group Limited has finished editing the document.	Yes

Dated Friday, 5 September 2014

## Executive Summary of Audit

### General Overview

Ranfurly Manor Ltd is a privately owned company which operates Ranfurly Residential Care Centre. A new, purpose built facility has been built, and opened, in Feilding, which has increased the size of Ranfurly Residential Care Centre to 113 beds. This includes a 20 bed dementia unit which on the first day of audit was occupied by eight residents. The new building has individual rooms for residents requiring hospital and rest home level care, and residential care suites which are occupied under license to occupy agreements by people who are assessed as requiring rest home or hospital level care. One area for improvement is identified at this spot surveillance audit. This relates to the food provided which residents report is unappealing and bland and does not meet their needs for appetizing meals.

### Outcome 1.1: Consumer Rights

Residents and families/whanau receive prompt and open communication. Records of all contact with families/whanau are maintained on the individual resident's file, and incident reports record notification when this is appropriate. Complaints are managed in line with the Code of Health and Disability Services Consumers' Rights and a complaints register is maintained.

### Outcome 1.2: Organisational Management

Ranfurly Residential Care Centre is privately owned. There is a general manager, who has oversight of Ranfurly Residential Care Centre and another aged care facility with the same owner. There is a facility manager based at Ranfurly Residential Care Centre, although they were on annual leave at the time of this unannounced spot surveillance audit. The service is managed on a day to day basis by the facility manager and in their absence the general manager takes over these responsibilities, with assistance from several other senior registered nurses in the facility.

There are governance, management and quality and risk management systems which are implemented at Ranfurly Residential Care Centre. These have been developed over time and include policies and procedures which describe these systems. All policies and procedures are controlled and managed and those seen on the days of audit are current. Quality improvement data is collated and analysed with trends and event data being regularly reported to staff through monthly staff meetings. All accidents/incidents and other exceptions to expected service delivery are reported and recorded. Collated incident/accident/event data is incorporated into the quality improvement system.

Human resources are managed by the facility manager and general manager. There is a structured programme of orientation and ongoing staff training which meets the requirements of these standards. Safe staffing levels are maintained and there is a documented process for allocating staff to each area within the facility.

### Outcome 1.3: Continuum of Service Delivery

There is evidence that residents' needs are assessed on admission by the multidisciplinary team. Care required is identified, co-ordinated, planned and reviewed in participation with the resident.



## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	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.	PA Low			
HDS(C)S.2008	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.	PA Low	Residents are dissatisfied with meals and when interviewed residents and family claim meals are "bland" and "lack appeal" which is also verified by observation and taste on the two days of the audit.	There is evidence of consumer satisfaction with meals provided.	180

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

# NZS 8134.1:2008: Health and Disability Services (Core) Standards

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## Outcome 1.1: Consumer Rights

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

### Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

**Attainment and Risk:** FA

**Evidence:**

At interview with a range of staff and managers (14 staff members and four managers) there is consistent reporting that communication with residents is open, honest and clear.

The range of training and education for staff members includes an emphasis on the rights of people who receive health and disability services (see standard 1.2.7) and during the audit there is evidence of this. Accident / incident monitoring (AIM) reports used to report and record all types of incidents include notification to families / whanau. There is a family contact form which is used on each resident's file to record contact with families/whanau for any reason. Progress notes record communication with residents, as well as daily interactions, care and support and interventions.

There are appropriate policies and procedures to guide staff in using interpreter services if and when needed for any resident. Currently there are no residents who require interpreter services.

ARC contract requirements are met.

### Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

Consumers have a right to full and frank information and open disclosure from service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)**

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)**

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

**Attainment and Risk:** FA

**Evidence:**

Complaints are recorded on service improvement forms. At interview with the general manager (GM) she reports that most residents and family/whanau do not like to talk about complaints but are more comfortable discussing an issue which will lead to improvements in the service. The use of service improvements enables a wide range of information to be recorded and included with this are occasional complaints.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is included in the orientation programme, ongoing training for all staff and the monthly in-service updates.

At interview with a group of nine staff members they easily describe the organisation's complaints process. At the reception desk at the main entrance there are service improvement forms available for use. There is a complaints register which is up to date. The register includes the date the complaint is made and actions taken to address and handle the complaint.

**Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)**

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)**

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## 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 (HDS(C)S.2008:1.2.1)

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

**Attainment and Risk:** FA

**Evidence:**

The purpose, values, scope, direction and goals of the organisation are described, and form the basis of, the business plan for Ranfurly Manor Ltd. This has led to the building of a new and larger Ranfurly Residential Care Centre in Monmouth street, Feilding. The goals are reviewed on the same three yearly cycle as the organisation's documents (see standard 1.2.3).

The organisation structure is described in a chart which is included within the policies and procedures. The GM has oversight of Ranfurly Residential Care Centre (RRCC) and another aged care facility in near by central Hawke's Bay. The GM is a registered nurse (RN) who has experience in public hospital settings, in both nursing care and leadership roles. She has worked for Ranfurly Manor Ltd for approximately five years, initially as the facility manager (FM) and in the last 3 months as the GM for Ranfurly and other facility. A new FM was appointed and commenced the FM role at RRCC in June 2014.

The new FM is also a RN, with a range of nursing experience in the United Kingdom and New Zealand. More recently she has worked in surgical nursing and in nursing leadership roles. Both the GM and FM have current annual practising certificates.

ARC and ARHSS contract requirements for governance of the organisation are met.

### Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The Facility Manager (FM) is on annual leave when this unannounced surveillance audit takes place. The GM has taken on the FM's role in her temporary absence and is assisted to do so by the newly appointed quality coordinator (a RN with a masters and PhD in nursing) and a clinical support RN who is an experienced nurse and has worked at Ranfurly Manor for some years. Apart from the clinical support RN, these members of staff are additional to the RN compliment on each wing of the facility, including the new dementia unit.</p> <p>ARC and ARHSS contract requirements for service management are met.</p>

### Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### **Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)**

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

**Attainment and Risk:** FA

**Evidence:**

There is a quality improvement policy which describes the quality and risk management system of the organisation. This includes quality improvement as an overall goal, focusing on service delivery and measuring particular aspects of service delivery to ensure high standards are met. The focus on quality improvement and procedures for reporting and recording exceptions to service delivery by all staff members, are included in the organisation's orientation programme.

The GM describes the document management and control system. There is an administration manager at RRCC who maintains the document control register, which is an electronic list of all policies, procedures and forms in use at the facility, their development date, three yearly review date and the person responsible for authorising any changes to the particular document. When reviewed the updated version of a document is denoted, along with the new review date, so it is clear when looking at each document whether it is current. Any document can be reviewed and updated more frequently if needed. Documents sighted on the days of the audit visit are current and have been reviewed following the organisation's process. While the GM coordinates the review of all documents, other staff are involved in the process according to the document itself, so that there is involvement of relevant staff and shared responsibility.

Service delivery is monitored through a range of measures from occupancy levels and satisfaction surveys, through to exception reports (see standard 1.2.4). There are monthly meetings of each functional team (caregivers, qualified nurses which include registered nurses (RNs) and enrolled nurses, housekeeping, kitchen staff, administration) and six monthly staff meetings with all staff members. At these meetings collated quality improvement data (AIM reports, complaints, compliments, infections, restraint and enabler use) are all reported and discussed with staff. A group of nine caregivers and housekeeping staff members report that this occurs regularly and they receive this information. The GM holds a monthly AIM briefing where she discusses this data in more depth and provides specific feedback, and planned corrective actions if these are needed, with staff.

Progress against the organisation's business plan and the quality improvement policy is measured through the regular and frequent contact between the GM and the director. She provides regular reports on occupancy levels, wages and staffing ratios, and budgeted projections for the new facility as occupancy increases. She verbally reports to the director on any resident / service delivery incidents and /or human resource issues which may impact on the business. With the opening of the new facility there is currently more informal and verbal reporting with progress on the ongoing building work on the additional residential care suite wing still under construction.

Formal corrective action plans are contained on the AIM form and on the quality improvement form. These allow for a documented, planned response to individual events or to identified trends or systemic issues which have been identified. In July 2014 the quality coordinator completed an internal audit of residents' clinical files and the results are as identified by this audit. (See standard 1.3.6). A quality improvement project has been developed on 27 July 2014 with a detailed corrective action plan to address these issues. The planned actions will provide an effective response. Evidence is seen of the first steps of the plan being implemented, that is, an example resident file with all associated documentation on appropriate forms in the relevant location on the file; appointments made with each qualified nurse (QN) and the quality coordinator to bring two of the assigned residents' files to review them and bring both up to date and ensure that the individual QN clearly understands the requirements

for documenting files.

There is a current risk register for RRCC which is maintained by the GM. The register is prepared in a format which is consistent with that of the MidCentral District Health Board (MCDHB). This is not a requirement of the MCDHB but their risk register was provided to all facilities and the GM chose to align RRCC's to this MCDHB register. The register includes appropriate identification of risks to the facility and the mitigation strategies. The register is monitored six monthly and has been reviewed most recently on 1 July 2014. Recently the register has been added to with risks relating to the development of the new facility and expansion in size. These are also appropriate to the stage of the construction. A newsletter, which is available at the main reception, mentions some of these risks to visitors which are appropriate to communicate.

ARC and ARHSS contract requirements for quality and risk management are met.

**Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)**

The organisation has a quality and risk management system which is understood and implemented by service providers.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)**

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)**

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)**

Key components of service delivery shall be explicitly linked to the quality management system.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)**

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

A process to measure achievement against the quality and risk management plan is implemented.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)**

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)**

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)**

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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

**Attainment and Risk:** FA

**Evidence:**

Essential notifications are included in the health and safety policies, infection prevention and control policies and in individual policies as needed. In the week prior to the unannounced surveillance audit there is a minor outbreak of gastroenteritis which is notified to public health at MCDHB. A copy of the email notification is provided to the DAA Group at the time of the notification.

There is an AIM policy and procedure which describes the recording of all exceptions to expected service delivery and how these are reported. The AIM form is used for most events. Infections are recorded on residents' files and one of the QNs on night shift monitors this data. Restraint and enabler use is monitored through the restraint coordinator's registers, and incidents and accidents are reported on the AIM form.

Collated data is shared with staff through graphed data, discussion at monthly staff meetings and in the GM's monthly briefing. At interview with a range of staff (14 caregivers, housekeeping, nursing staff and four managers) this sharing of collated data and trends in event data is confirmed.

ARC and ARHSS contract requirements for adverse event management are met.

**Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)**

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)**

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

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

**Attainment and Risk:** FA

### **Evidence:**

There are well described human resource management systems at RRCC which include the recruitment and appointment of employees, orientation, training and on-going education, performance development and management and for associated good employment practices.

Professional qualifications are validated during recruitment and annually by the administration manager. A copy of the annual practising certificate (APC) for all qualified nurses employed by RRCC is maintained on their personnel file. The administration manager uses her 'Outlook calendar' as a reminder system to follow up when these are due, if the individual nurses do not bring their APC to her on its renewal first. Evidence of other qualifications (e.g. Careerforce qualifications held by caregivers, the diversional therapist, food hygiene certificates) are also maintained on personnel files. Copies of practising certificates for visiting health and allied health certificates are held on a separate file by the administration manager (AM).

Recruitment of new staff members is undertaken by the GM and FM with coordination by the AM now that there is a full time receptionist at the facility and the AM has been freed up from this task. Seven personnel files are sampled during the onsite audit and confirm that a consistent recruitment process is followed, as described in the organisation's policies and procedures. All new employees have an interview, reference checks and a police check conducted before they are appointed to their position. Seven of seven files have evidence of this occurring although for some files for long serving staff the process followed is now different from that at the time of their appointment.

There is a consistent orientation which incorporates completion of employee documentation, an introduction to RRCC, health and safety briefings including fire and evacuation systems, and review of key policies and procedures relevant to the provision of health and disability services, (ie, the Code, residents' rights, complaints, AIM reporting, safe use of chemicals / equipment / hazards). A checklist is used to record completion of this orientation by the person's immediate supervisor within their first week (approximately). Caregivers then commence working on the Careerforce level 3 core competencies certificate. RRCC has selected the unit standards it wants to make up this certificate. The caregiver coordinator (CGC), an EN who has worked at MCDHB and is a workplace assessor, provides coaching and support to the caregivers as they complete each unit standard and assesses them at completion of the workbook. The aim is that each caregiver will complete the certificate within 18 months. Caregivers working in the dementia unit, who do not already have the dementia qualification, are supported to complete this, with the additional unit standard 23391 – Loss & grief. At interview with the CGC she goes through her records of tracking the completion of the qualifications by those caregivers who have not yet completed.

There are currently 45 caregivers on staff at RRCC. Six of these caregivers work in the dementia unit. Of these six, five already hold the dementia qualification and the remaining one caregiver will commence work on the qualification soon. The other 39 caregivers work across the rest home and hospital wings. 12 have completed the full Certificate in Aged Care. 15 have commenced their core competency certificate. There are 9 RN students on staff, working as caregivers, who are exempt from completing the NZQA cert while doing their BN Nursing. 2 staff are in their first 3 months and will not enrol in program until their 3 month review. The qualified nurses are supported to complete their required professional development hours for their practising certificates.

There is an annual training calendar which includes monthly in-service training sessions on topics which are scheduled as needed based on AIM data, infections, and trends, incontinence products and other products or consumables used in the facility. Scheduled annual training includes the safe use of chemicals, sling hoists, manual handling, abuse and neglect and discrimination and medication management and annual medication competency. Biennial training includes level 2 resus certificates for caregivers, level 4 CPR for qualified nurses.

All staff members interviewed (14 caregivers and qualified nurses and four managers) report that they receive appropriate training to be able to do their jobs safely and well. They describe the training received which is consistent with the documented training calendar, the organisation's policy and procedure on ongoing education, and confirms the reported provision of training at interview by the GM, CGC and QC during separate interviews.

ARC and ARHSS contract requirements for human resource management are met.

**Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>RRCC has a staff clinical duty roster policy which describes the safe rostering practice which occurs in the facility. The GM reports at interview that she planned with the director the levels of staffing which would be implemented as the numbers of residents began to increase with the move from the old Ranfurly Manor facility, which occurred in December 2013. The projection in the business plan was for full occupancy to current available bed numbers to be achieved over 18 months from opening.</p>

(Full occupancy of available rest home and hospital beds, excluding those in residential care apartments, and the dementia unit (RDC), has already been achieved.) Staffing levels, with ratios of registered nurses (RN)s and caregivers, were agreed with the direction and the GM was able to recruit and appoint additional staff as resident numbers increased.

The current roster reflects both a change in the structure of staff teams and staff numbers with the move to the new facility. RRCC has three wings (A, B and C wings) with 25 beds in each wing, and a mix of rest home and hospital care is provided. There are currently 15 residential care suites (11 single suits and four doubles) with 10 single suites occupied and two double suites occupied. The residential care suites are located in C wing. In the 20 bed dementia wing there are eight residents on the first day of the audit.

On the morning and afternoon shifts every day of the week there is a RN on duty on each of A, B and C wings, the dementia wing (RDC), and the residential care suites, with additional caregivers as follows:

RDC:

morning shift: 1 care giver is on duty 7 am – 3.30 pm, and 1 on duty 7 am to 1pm;

afternoon shift: an EN is on duty 3pm – 11pm, 5 days a week on a four on / two off roster, with a caregiver on duty for the same hours on the days the EN is not on duty, and there is also another caregiver on duty 3pm – 11pm;

night shift: 1 staff member is on duty 10.45pm – 7.15am (either an EN or a caregiver) two staff members share this shift on a four on / two off roster. (See also A, B, C wing RN cover for night shift).

A, B and C wings (including the residential care suites in C wing):

morning shift: (on each wing) 1 RN on duty 7am – 3pm, 1 caregiver on duty 7am – 3pm, 2 caregivers on duty 7am – 1pm, 1 caregiver on duty 8am – 2.30pm

afternoon shift: (on each wing) 1 RN on duty 2.30 – 11pm, 1 caregiver on duty 2.30pm – 11pm, 1 caregiver on duty 3.30pm – 7.30pm, 1 caregiver on duty 3.30pm – 8.30pm, 1 caregiver on duty 4 – 10 pm and 1 caregiver on duty 3.30 – 11pm.

night shift: 2 RNs cover all three wings and the RDC, with (on each wing) 1 caregiver on duty 10.45pm – 7am

With the move to the new and much larger facility, the GM, after consultation with staff and the RNs, restructured the teams. There is a clinical support RN who was the clinical nurse leader. She is now the clinical support RN and works on afternoon shifts Monday to Friday. On Mondays and Tuesdays she is supernumery to the roster and undertakes tasks related to her role as infection prevention and control coordinator and restraint coordinator. From Wednesday to Friday she is rostered on as the QN on C wing. The QNs on duty reports to the FM and are the team leader for the wing they work on.

The laundry and house-keeping teams also have a team leader who provides oversight and supervision to the team and is involved in the rostering of the team.

Laundry: There are six staff members in the laundry team. The team leader starts at 5 am and works until 2 pm although other staff who work the morning shift work from 8 am to 4.30 pm. The afternoon staff member works from 1 pm to 9 pm. On Saturday and Sunday the morning shift is from 6 am to 2 pm.

House-keeping: Monday – Friday: there are three staff members on duty 7.30 am – 4 pm, who work in the three wings with one of the staff members currently including the RDC in their area. The cleaning schedules for week days include a basic clean for all areas, and a full clean for five rooms a day. Saturday and Sunday there are two staff 7.30 am to 4 pm, who cover the facility and carry out a basic clean, unless a full clean is needed.

The caregivers now report to a caregiver coordinator. This position was appointed internally. She is an EN who has worked for Ranfurly for 5 years. She has acute experience in MCDHB and is a qualified workplace assessor for Careerforce.

At interview with 14 staff members (this includes the housekeeping and laundry team leaders, four RNs, three care givers and other staff), they talk about the initial difficulties and stresses of moving to the larger facility. While the change was difficult they report they have now got used to the changes. New staff members have been appointed and trained and they report that staffing levels are sufficient to meet residents' needs and staff can complete their jobs safely. One staff member who has been on parental leave reports a marked improvement on their recent return to work and there is agreement that the structure is working well. The FM and GM are complimented by a range of staff members interviewed. They provide support and appropriate leadership.

### Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## 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 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Each stage of the service provision at Ranfurly Residential Care Centre is undertaken by suitably qualified providers and is developed with the resident and their family/whanau. Within 24 hours of admission the registered nurse (RN) undertakes an initial assessment that includes gathering data from the resident, their family/nominated representative, the needs assessment and co-ordination service and/or previous providers of personal care services. Data gathered informs the documented plan of care required by staff to attend to the residents' immediate needs. A medical assessment is conducted by the resident's general practitioner (GP) within 24 hours of admission and the medical treatment programme required by the resident is documented. This serves as the basis for care planning to cover a period of up to three weeks.</p> <p>Within three weeks of admission the RN completes a long term care plan, based on the collection of comprehensive assessment data. The long term care plan directs the care required to meet the resident's need and desired outcome. Progress notes, recording the daily progress of the resident, are documented by the care staff providing the care and the RN (where RN input is required) each shift. The ongoing assessments, interventions and evaluation is completed and documented by the RN in consultation with the resident, family and allied professionals as residents' needs change. The care plan is evaluated every six months or as needs change to ensure the appropriate care is provided and the resident's desired outcomes are being met. Ongoing medical review is undertaken either monthly or three monthly if the medical</p>

practitioner deems the resident to be stable. The resident's medication is reviewed three monthly or as needs change and this is conducted by the GP, as sighted.

Family contact is documented in the progress notes and family contact record. Evidence of this is sighted in files (three of three dementia, six of six hospital and five of five rest home residents) reviewed and verified by interviews (nine of nine residents and four of four residents family/whanau). Residents and family/whanau interviewed are happy with the quality of care that is provided.

Registered nurses practising certificates, training records and CPR certificates are sighted. The registered nurse acts as the resident's case manager and is responsible for planning, reviewing and overseeing all aspects of the resident's care. The RN in charge of the dementia unit has recent training and experience in dementia care, as verified by interview and training records. Caregivers with experience, education and training in aged care and dementia care (as evidenced by training records) provide most of the direct provision of care. The in-service education programme (sighted) contains the required education for the staff to meet contractual requirements. The cooks and kitchen assistants have qualifications in food safety training. The contracted podiatrists provide services to the residents. The annual practising certificates (APCs) are sighted for all other staff and contracted staff that require an APC.

An RN oversees the residents whose care they are responsible for planning. Residents are attended to by their GP of choice. A verbal handover from the resident's RN occurs at the beginning of each shift and the RN then hands over to care staff to ensure all staff is familiar with the residents' needs. Health professionals are allocated the residents they are to deliver the daily care to, under the guidance of the RN, and write in the resident's progress notes at the end of each shift. Hand over sheets document daily changes that require attention. Resident notes are integrated, demonstrate input from a variety of health professionals, and are responsive to the assessed needs of the resident, including amendments to care plans and goals for the resident as appropriate. Timely access to other health providers is evident in residents' files.

The ARRC contract requirements are met.

Tracer methodology one – Hospital resident.

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Tracer methodology two – Rest home resident.

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Tracer methodology three – Dementia resident

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

### **Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)**

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)**

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)**

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

**Attainment and Risk:** FA

**Evidence:**

The care and services at Ranfurly Residential Care Centre (RCC) are delivered in a safe and respectful manner.

The provision of care is consistent with the desired outcomes in residents' files reviewed which document the residents' physical, social, spiritual and emotional needs and desired outcomes. Interventions are detailed, accurate and meet current best practice standards; however there is no systematic approach to the documentation process (refer 1.2.3). A quality improvement project is in place to address these issues.

Interviews with residents and family/whanau members expressed satisfaction with the care provided and new residents verify they are welcomed and orientated to the facility. There are sufficient supplies of equipment that complies with best practice guidelines and meets the resident's needs (sighted). An interview with a GP verified satisfaction with the services provided by Ranfurly RCC to his residents.

The ARRC requirements are met.

### Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

### Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

**Attainment and Risk:** FA

**Evidence:**

A qualified diversional therapist plans the activities programme at Ranfurly Residential Care Centre. The dementia unit does have its own programme operating, though residents often join in with activities provided for the hospital, rest home and apartment residents if appropriate. As resident numbers increase in the dementia unit a second diversional therapist will become increasingly more involved with the activities on offer.

On admission, residents are assessed to ascertain their needs and appropriate activity requirements. The activities assessments and plans include the resident's preferences, social history, and past and present interests. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in the activity assessment data.

Activities reflect ordinary patterns of life and include normal community activities (e.g. guest speakers, visiting entertainers, visits by the local schools, craft clubs and church services). Family/whanau and friends are welcome to attend all activities and are welcome to visit their relatives. Group activities are developed according to the needs and preferences of the residents who choose to participate. The GM believes there will be two vans and is expecting the first one to arrive soon. Any resident requiring access to appointments or disability services is assisted by using local mobility van services.

Individual activity assessments are updated or reviewed at least six monthly with a monthly summary of the resident's response to the activities, level of interest and participation recorded.

A residents' meeting has just been held and meeting minutes reviewed evidence that the activities programme is discussed. The planned yearly resident/relative satisfaction survey will capture feedback on the activities programme. Residents and family are satisfied with the activities offered. The diversional therapist interviewed reports feedback is sought from residents during and after activities.

The ARRC requirements are met.

### Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)**

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

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

**Attainment and Risk:** FA

**Evidence:**

Evaluation of resident care is undertaken on a daily basis and documented in the progress notes. If any change is noted it is reported to the RN, who may contact the GP if requested. Family/whanau are kept informed of changes.

Formal care plan evaluations are conducted by the RN at least six monthly or as needs change. Evaluation measures the degree of achievement or response of each resident related to their goals six monthly. Where progress is different from expected, the service responds by initiating changes to the service delivery plan. When a resident is not responding to the services or interventions, changes are initiated to the care plan.

Evidence of evaluation is sighted in files reviewed. Resident and family interviews verify they are included and informed of all care plan updates and changes.

The ARRC requirements are met.

**Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The Medication Management Policy at Ranfurly Residential Care Centre is comprehensive and identifies all aspects of medicine management including safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in order to comply with legislation, protocols and guidelines.</p> <p>Medicines for residents are received from the pharmacy in the Douglas Pharmaceuticals Medico Pak delivery system. A safe system for medicine management is observed on the day of audit. The staff observed demonstrate good knowledge and have a clear understanding of their roles and responsibilities related to each stage of medicine management. Registered Nurses - RNs (RN's &amp; EN's) administer all medications at Ranfurly (RRCC) other than in the dementia unit, where care staff who have been deemed competent, administer medications that have been dispensed in the Medico Pak delivery system, when an RN is not on duty. All care staff who administer medicines in the dementia unit have current medication competencies (sighted). The RN in charge of the dementia unit monitors medication competencies.</p> <p>Controlled drugs are stored in a separate locked cupboard. Controlled drugs, when dispensed are checked by two RNs for accuracy in dispensing. The controlled drug register evidences stock checks and reconciliations recorded. The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range</p> <p>The medicine prescription is signed individually by the GP. The GP's signature and date are recorded on the commencement and discontinuation of medicines. Residents' photos, allergies and sensitivities are recorded on the medicine chart. Sample signatures are documented. All medicine charts reviewed have fully completed medicine prescriptions and have signing sheets including approved abbreviations when a medicine has not been given. The three monthly GP review is recorded on the medicine chart.</p> <p>There are two residents who self administer their medicines at the time of audit. The sighted assessments for self administration is in these files reviewed and meet the facility's policy.</p>

Medication errors are reported to the RN, recorded on an incident form, investigated and analysed. The resident and/or the designated representative are advised. Records of drug errors on incident forms are sighted and evidence that analysis processes are in place to manage medication errors.

Standing orders are not used at RRCC.

The ARRC requirements are met

**Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

**Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)**

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)**

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> The food, fluid and nutritional requirements of the residents at Ranfurly Residential Care Centre are provided in line with recognised nutritional guidelines for older people as verified by the dieticians documented assessment of the planned menu, that changes seasonally (sighted).

Training records verify the cook and kitchen staff are trained in food and hygiene safety. An external provider monitors chemical use, cleaning and food safety in the kitchen and inform the facility with monthly reports and recordings. A cleaning schedule is sighted as is verification of compliance.

There is evidence to support sufficient food is ordered and prepared to meet the residents' recommended nutritional requirements (cooked meat, chicken or fish and fresh fruit 100gm/day). Between meal snacks are available at all times in the dementia unit, as sighted and verified by resident, staff and family/whanau interview.

A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs are sighted.

Residents are dissatisfied with meals and this is an area requiring improvement as is verified by eight of nine residents and four of four family/whanau and staff interviews. Residents claim meals are "bland" and "lack appeal" and this is verified by observation and taste on the two days of the audit.

There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed (sighted and roster reviewed). The dining rooms are clean, warm, light and airy to enhance the eating experience.

Food is ordered by the cook on a weekly basis. Fruit and vegetables are ordered daily depending on need and availability and meats and fish are ordered three times per week. When food is delivered it is checked for 'use by date' and damage then stored in well organised and appropriately temperature controlled storage. Fridge, freezer, and cooked meat temperatures are monitored daily. Records sighted verify records within accepted parameters. Raw meat is stored at the bottom of the fridge and is completely thawed before cooking. Any leftovers are covered and labelled with the date/time/contents. Leftovers are not reheated more than once. Leftovers are discarded if older than two days.

The ARRC requirements are met.

### **Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)**

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

**Attainment and Risk:** PA Low

**Evidence:**

A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment to meet resident's nutritional needs is sighted. Dissatisfaction with meals is verified by eight of nine residents and four of four family/whanau and staff interviews stating such things as meals are "bland" and "lack appeal".

**Finding:**

Residents are dissatisfied with meals and when interviewed residents and family claim meals are "bland" and "lack appeal" which is also verified by observation and taste on the two days of the audit.

**Corrective Action:**

There is evidence of consumer satisfaction with meals provided.

**Timeframe (days):** 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

### Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## 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.

## Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

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

**Attainment and Risk:** FA

### Evidence:

RRCC is a new facility which has been purpose built and designed to provide services to people who require rest home, hospital and dementia care services. The building, plant and equipment are new and fit for purpose, including furniture in residents' rooms, communal areas, dining and activity rooms. The two previous areas requiring improvement have been addressed.

The current certificate of compliance, issued on 26 May 2014 is valid through to 29 August 2014. There is construction of an additional wing of 31 residential care suites (for 37 residents) still be completed at one end of the current facility. (This area of construction is not accessible to residents or visitors and can only be reached through staff only corridor and doorway with clear signage.)

The facility has wide corridors, handrails throughout, the low rolling resistance carpet repels liquids and is stain resistant, windows in bedrooms can be opened and are on safety latches, all windows and glazing is double-glazing and the building has insulation and under floor heating.

There are internal courtyards which are level, and accessible through doorways from communal areas which are on the same level as the courtyard / garden. In the RDC there is a secure, fenced courtyard and garden which is accessible from the unit. Door alarms activate when the doors are opened, but this is simply to let staff know that someone has gone outside. The gardens / courtyard for the unit are completely self-contained and surround the two wings of the RDC's bedrooms but do not open onto any of the other garden areas of the facility.

ARC and ARHSS contract requirements for the facility are met.

### Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

### Evidence:

### Finding:

### Corrective Action:

**Timeframe (days):** *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

#### Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

#### Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Orientation and annual training includes fire and evacuation training and emergency response procedures. The new evacuation scheme for the RRCC has been approved by the local fire service on 5 November 2013 and is in place at the facility. There have been practices of the new evacuation plan since the move to the Monmouth Street facility. The most recent practice occurred after the opening of the RDC on 9 June 2014 and was conducted in the presence of Reliance Managed Services. This

evacuation was conducted “in a safe, prompt and efficient manner.” The previous required improvement has been addressed.

There is a 10,000 litre water storage tank installed which is filled from main supplies but is continuously full. This provides the emergency water supplies in the event of main supplies failing and is sufficient for recommended initial amounts in a civil defence emergency. A large stand free standing barbeque is powered by gas bottles. This will provide cooking facilities for an emergency (as well as summer barbecues).

There is an electronic call bell system throughout the new facility. There are activation points in each bedroom, in both the bedroom and living area of the residential care suites and in the communal areas of the facility. The light displays are easily visible in the corridors and the bell sound is audible throughout. Call bells when activated are observed to be responded to within reasonable times during the onsite audit visit.

There are cameras on all entrance / exits. The cameras showing the main entrance and exits onto the car park at the front of the building are on display at the reception desk. (These cameras do not pick up resident rooms or communal areas, only doorways.) While the cameras are not continuously monitored they can be from the reception desk and by the FM and GM via secure, password protected, internet access. Digital recordings are maintained for a week and then deleted. These cameras are part of the security systems which include the locking of external doorways at 8pm and unlocked at 6.45am. The doors are linked to the call bell and phone system so that they can be automatically locked / unlocked with an appropriate access code and password.

**Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)**

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>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)**

Where required by legislation there is an approved evacuation plan.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> 180 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

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### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

#### **Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<p>Enablers are used on request and are recorded and monitored through the same process as restraints, by the facility's restraint coordinator. She is interviewed during the onsite audit and a sample of files for residents who use enablers is reviewed.</p> <p>Enabling equipment may be requested on entry to the facility as part of the initial assessments for nursing and care supports, or during part of regular reviews of support. On the files sampled on the day of audit (three), there are enabler authorisation forms on each file which have been signed by the resident (two of three) and a family member on behalf of a resident (one of three). These are completed through the entry assessment (two) and regular review (one). All three are listed on the enabler register compiled by the restraint coordinator who is the clinical support RN at the most recent restraint / enabler meeting.</p> <p>The enabler authorisation form indicates that the specific enabling equipment (bedrails for all three residents) are requested by them, and the reason for this. In each case</p>

this is given as being for safety and security for the resident. The clinical support RN / restraint coordinator confirms that equipment which is requested for use by residents for their safety and security is considered an enabler.

**Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)**

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

## NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

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**Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)**

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>In line with the infection control (IC) policy and procedures at Ranfurly Residential Care Centre, monthly surveillance is occurring. The type and frequency of surveillance is as determined by the infection control programme. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month are recorded on an infection report form and graphed. These are collated each month and analysed to identify any significant trends or possible causative factors. Currently there is a qualified nurses meeting every four to six weeks and a staff meeting every four to six weeks where the incidents of infection are presented. Any actions required after analysis are implemented. Outcomes are presented to staff at daily handover and staff meetings and any necessary corrective actions discussed. A recent gastrointestinal outbreak in the facility is recorded in the infection incident statistics in the last month and has been managed and contained as per guidelines and is now resolved. As a result of analysis future management of new admissions from other facility will incorporate standard isolation of those residents for 48 hours.</p>

**Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)**

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>