Ranfurly Village Hospital Limited

CURRENT STATUS: 30-Jul-13

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the 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 Care and Veterans Facility is managed by a registered nurse who has experience of working as an operations manager and general manager in aged care facilities both in New Zealand and Australia. Ranfurly Care provides hospital-geriatric, rest home and dementia level care for up to 129 residents across three units. There were 45 rest home residents and 31 hospital residents and 24 dementia level care residents at the time of audit. The service has decommissioned 17 rest home beds in the older part of the building which were unoccupied and needed repairs as the service is in the process of building a new purpose built facility on site which will be ready later in 2013.

This audit identified improvements required around documentation of informed consent, documentation of residents beliefs and values, the use of clinical assessments, aspects of medication management, documentation of activity/recreational plans and chemical safety.

A provisional audit was completed due to a change of legal entity. Ranfurly Village Limited (RVL) purchased a lease from Ranfurly Veteran Care Limited in October 2012 and the rights to develop the current site. Ranfurly Village Limited also took over the operation of the aged care services in October 2012. No changes will occur to the current organisational structure. The current structure will transfer from Ranfurly Care Limited to Ranfurly Village Hospital Limited. There will be no changes to key personnel, organisational management, or clinical management/leadership staff.
Ranfurly Care and Veterans Facility
Ranfurly Village Hospital Ltd

Provisional audit - Audit Report

Audit Date: 30-Jul-13
Audit Report
To: HealthCERT, Ministry of Health

**Provider Name** | Ranfurly Village Hospital Ltd  

<table>
<thead>
<tr>
<th>Premise Name</th>
<th>Street Address</th>
<th>Suburb</th>
<th>City</th>
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<tr>
<td>Ranfurly Care and Veterans Facility</td>
<td>539 Mt Albert Road</td>
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**Proposed changes of current services** *(e.g. reconfiguration)*:

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**Type of Audit** | Provisional audit and *(if applicable)*  

**Date(s) of Audit** | Start Date: 30-Jul-13 | End Date: 31-Jul-13  

**Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited
## Audit Team

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<th>Name</th>
<th>Qualification</th>
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<th>Auditor Dates on site</th>
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### Total Audit Hours

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<td>GP’s Interviewed (aged residential care and residential disability) (numeric)</td>
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Declaration

I, (full name of agent or employee of the company) XXXXXXXX (occupation) Director of (place) Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 30 day of August 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

<table>
<thead>
<tr>
<th>Premise Name</th>
<th>Total Number of Beds</th>
<th>Number of Beds Occupied on Day of Audit</th>
<th>Number of Swing Beds for Aged Residential Care</th>
<th>Hospital Care</th>
<th>Rest Home Care</th>
<th>Residential Disability Care</th>
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<td>112</td>
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- Children's Health Services
- Geriatric Services (excluding dedicated Psychiatric 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
Executive Summary of Audit

General Overview

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1.1 Consumer Rights

Residents and their families/whānau are informed of their rights as part of the resident information pack. Residents stated that Health Care Assistants always respected their privacy and this is reinforced through the training with caregivers. Initial and ongoing assessment includes gaining details of people’s beliefs and values. However there is an improvement required around the documentation of residents beliefs and values. Residents are encouraged to continue with their spiritual activities.

Cultural awareness training occurred as part of the annual training programme. There is Maori Health Plan which has been revised and implemented.

Residents and relatives spoke positively about care provided at Ranfurly Hospital. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the code of rights and services is readily available to residents and families. Policies are implemented to support residents’ rights. Annual staff training supports staff understanding of residents’ rights. Care plans accommodate the choices of residents and/or their family/whānau. There is an improvement required around the use of consent forms (resuscitation). Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified on-going involvement with community.

1.2 Organisational Management

The service has an established quality business plan. Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings. The quality and risk management systems are continually reviewed. Quality actions have resulted in a number of quality improvements for both residents and staff. There is an active health and safety committee. There are human resources policies including recruitment,
selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is a comprehensive in-service training programme covering relevant aspects of care and support and external training is well supported. Staff working in the dementia unit have completed NZQA education modules in dementia care. There is a charter in place which includes standards of care and minimum staffing levels and aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff and resident input into rostering.

1.3 Continuum of Service Delivery

The service has a policy for admission and entry for rest home, hospital or dementia care unit. A service information pack is made available prior to entry or on admission to the resident and family/whanau. Residents/relatives confirmed they received admission information and that the admission agreement is discussed with them. The Registered nurse in each unit is responsible for each stage of service provision. The assessments and long term care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provide evidence that the provider has implemented systems to plan and evaluate care needs of the residents. The residents' needs, goals and interventions, have been identified in the long term care plans and these are reviewed at least six monthly or earlier if there is a change to health status. There is evidence in the resident files that there is resident and/or family/whanau and multidisciplinary team input into the six monthly reviews. There is an improvement required around the use of assessment tools for wounds and continence problems. Short term care plans for acute episodes or short term needs. Resident files are integrated and include notes by the GP and allied health professionals.

Each unit has a separate "What's on" activity programme delivered daily. There is variety, interest and choice that promotes resident independence, involvement, emotional wellbeing and social interaction appropriate to the level of physical and cognitive abilities of the resident group. There is a requirement to develop individual 24 hour activity plans for residents in the dementia care unit.

Education and medicines competencies are completed by RN's who are responsible for administration of medicines. All medication is reconciled on delivery and stored safely. The medicines records reviewed include photo identification, documentation of allergies and sensitivities and special instructions for administration. There are improvements required to aspects of medicine management. The GP is required to prescribe the route of administration on the medication charts and PRN medications require an indication for use on the medication drug forms.

Medirest are contracted to provide food services and all meals on site. Residents individual food preferences, dislikes and dietary requirements are met. The menu is developed by the Medirest dietitian and reviewed regularly. All staff are trained in food safety and hygiene.

1.4 Safe and Appropriate Environment

Ranfurly Care Limited has hospital and rest home level of care in one facility and a dementia care unit in another building within the same grounds. The buildings have a current building warrant of fitness and fire service evacuation approval. There are some shared four bedded rooms in the older hospital ward with all other rooms single. Rooms are personalised and spacious. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are spacious and well utilized for group and individual activity. The dining and lounge seating placement encourages social interaction within the rest home and hospital areas. The dementia care unit has an open plan dining and lounge area with
quieter areas appropriate to meet the individual needs. There are outdoor areas that are safe and accessible for the rest home and hospital. The dementia unit has safe outdoor access and walkways. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. Chemicals are stored safely on delivery. The laundry and cleaning service are contracted out to Medirest. The site laundry operates throughout the day. The cleaning service maintain a tidy, clean environment. There is a requirement to ensure cleaning trolleys with chemicals are not left unattended. There are policies and procedures to guide staff in the management of emergencies/civil defence. There are enough emergency supplies to last for at least three days. All key staff hold a current first aid certificate.

2 Restraint Minimisation and Safe Practice

Ranfurly Care Limited has a comprehensive restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers.

The policy includes that enablers are voluntary and the least restrictive option. There is one resident with an enabler (bedrail) in use and five residents requiring the use restraints (bedrails). Staff receive training on restraint minimisation and managing residents' behaviours that can be challenging.

3 Infection Prevention and Control

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator (the care manager who is a registered nurse) along with the education and health and safety coordinator is responsible for coordinating/providing education and training for staff. The infection control co-ordinator has attended external training. Infection control training is provided at least twice each year for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.
### Summary of Attainment

#### 1.1 Consumer Rights

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<tr>
<th>Standard 1.1.1</th>
<th>Consumer rights during service delivery</th>
<th>Attainment</th>
<th>CI</th>
<th>FA</th>
<th>PA</th>
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Consumer Rights Standards (of 12): N/A:0 CI:0 FA:10 PA Neg:0 PA Low:2 PA Mod:0 PA High:0 PA Crit:0

Criteria (of 48): CI:0 FA:21 PA:2 UA:0 NA:0
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Continuum of Service Delivery Standards (of 12): N/A:0, CI:0, FA:10, PA Neg:0, UA:0, NA:0, PA Crit:0

Criteria (of 51): CI:0, FA:19, PA:2, UA:0, NA:0
## 1.4 Safe and Appropriate Environment

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<td>FA</td>
<td>0</td>
<td>3</td>
<td>0</td>
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<td>1.4.3</td>
<td>Toilet, shower, and bathing facilities</td>
<td>FA</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>1.4.4</td>
<td>Personal space/bed areas</td>
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<td>0</td>
<td>1</td>
<td>0</td>
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<td>1.4.5</td>
<td>Communal areas for entertainment, recreation, and dining</td>
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<td>1</td>
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<td>1.4.6</td>
<td>Cleaning and laundry services</td>
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<td>2</td>
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<td>1.4.7</td>
<td>Essential, emergency, and security systems</td>
<td>FA</td>
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<td>5</td>
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<td>1.4.8</td>
<td>Natural light, ventilation, and heating</td>
<td>FA</td>
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Safe and Appropriate Environment Standards (of 8): N/A:0 CI:0 FA:7 PA Neg:0 PA Low:1 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:16 PA:1 UA:0 NA:0
## Restraint Minimisation and Safe Practice

<table>
<thead>
<tr>
<th>Standard 2.1.1</th>
<th>Restraint minimisation</th>
<th>Attainment</th>
<th>CI</th>
<th>FA</th>
<th>PA</th>
<th>UA</th>
<th>NA</th>
<th>of</th>
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</thead>
<tbody>
<tr>
<td>Standard 2.2.1</td>
<td>Restraint approval and processes</td>
<td>FA</td>
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<tr>
<td>Standard 2.2.2</td>
<td>Assessment</td>
<td>FA</td>
<td>0</td>
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<tr>
<td>Standard 2.2.3</td>
<td>Safe restraint use</td>
<td>FA</td>
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<tr>
<td>Standard 2.2.4</td>
<td>Evaluation</td>
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<tr>
<td>Standard 2.2.5</td>
<td>Restraint monitoring and quality review</td>
<td>FA</td>
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Restraint Minimisation and Safe Practice Standards (of 6): N/A: 0, CI: 0, FA: 6, PA Neg: 0, PA Low: 0, PA Mod: 0, PA High: 0, PA Crit: 0

Criteria (of 21): CI: 0, FA: 9, PA: 0, UA: 0, NA: 0
### Infection Prevention and Control

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>Attainment</th>
<th>CI</th>
<th>FA</th>
<th>PA</th>
<th>UA</th>
<th>NA</th>
<th>of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard 3.1</td>
<td>Infection control management</td>
<td>FA</td>
<td>0</td>
<td>3</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>Standard 3.2</td>
<td>Implementing the infection control programme</td>
<td>FA</td>
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<td>Standard 3.3</td>
<td>Policies and procedures</td>
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<td>Standard 3.4</td>
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<td>Standard 3.5</td>
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Infection Prevention and Control Standards (of 5):
- N/A: 0
- CI: 0
- FA: 5
- 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: 9
- PA: 0
- UA: 0
- NA: 0

Total Standards (of 50)
- N/A: 0
- CI: 0
- FA: 45
- PA Neg: 0
- PA Low: 5
- 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: 96
- PA: 5
- UA: 0
- N/A: 0
Corrective Action Requests (CAR) Report

Provider Name: Ranfurly Village Hospital Ltd
Type of Audit: Provisional audit

Date(s) of Audit Report: Start Date: 30-Jul-13  End Date: 31-Jul-13
DAA: Health and Disability Auditing New Zealand Limited
Lead Auditor: XXXXXXX

<table>
<thead>
<tr>
<th>Std</th>
<th>Criteria</th>
<th>Rating</th>
<th>Evidence</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.6</td>
<td>1.1.6.2</td>
<td>PA Low</td>
<td>Finding: One resident file reviewed, did not document the resident's spiritual needs and how these affected other aspects of care e.g. the use of no blood products. Action: Ensure care plans address the spiritual needs of residents</td>
<td>3 months</td>
</tr>
<tr>
<td>1.1.10</td>
<td>1.1.10.7</td>
<td>PA Low</td>
<td>Finding: Four of ten resuscitation forms reviewed were completed incorrectly. GP has signed the resuscitation forms to state Not for Resuscitation, and had written across the resuscitation forms &quot;CPR inappropriate due to dementia&quot; and forms were evidenced signed by GP and consent by EPOA. Action: Ensure that resuscitation forms are completed correctly.</td>
<td>3 months</td>
</tr>
<tr>
<td>1.3.4</td>
<td>1.3.4.2</td>
<td>PA Low</td>
<td>Finding: There are no wound assessments for four chronic wounds in the rest home. b) There is no evidence of continence assessments for two hospital and two dementia care residents with incontinence problems identified on admission c) The individual recreational plan for residents in the dementia unit did not cover the 24 hour period. Action: a) Ensure that wound care assessments are completed for all wounds b) ensure continence assessments are completed for residents with identified incontinence problems and c) ensure that individual recreational plans are completed to cover a 24 hour period.</td>
<td>3 months</td>
</tr>
</tbody>
</table>
| 1.3.12 | 1.3.12.1 | PA | Low | **Finding:**  
(a) The hospital fridge has three consecutive weeks of temperatures at 0 degrees Celsius. The rest home fridge has eight consecutive weeks of temperatures at 10 degrees Celsius. There is one temperature recording for the dementia unit fridge since March-13. There is no corrective action taken for temperatures outside of the acceptable range.  
(b) There is no route of medication administration prescribed in 20 of 20 medication charts and no indication for use of PRN medications in 14 of 20 medication charts.  
**Action:**  
a) Ensure there is a route of medication prescribed and the indications for use of PRN medications is documented on medication charts by the GP.  
b) Ensure that medication fridge temperatures are recorded and any reading outside the optimum range are reported and corrective action completed. | 3 months |

| 1.4.1 | 1.4.1.1 | PA | Moderate | **Finding:**  
A cleaning trolley was noted to be left unattended in the dementia care unit. Personal cares trolleys with chemical bottles are observed as being left unattended in the corridors (Hospital) several times throughout the two day audit.  
**Action:**  
Ensure cleaning and personal cares trolleys are not left unattended at all times. | immediately - 1 month |
Continuous Improvement (CI) Report

Provider Name: Ranfurly Village Hospital Ltd
Type of Audit: Provisional audit

Date(s) of Audit Report: Start Date: 30-Jul-13    End Date: 31-Jul-13
DAA: Health and Disability Auditing New Zealand Limited
Lead Auditor: XXXXXXXX
1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

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 1.1.1 Consumer Rights During Service Delivery

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a  ARHSS D1.1c; D3.1a

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

Policies and procedures that adhere with the requirements of the Code of Health and Disability Services Consumer Rights are in place. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about rights at induction and through on-going in-service training and competency questionnaires. Interviews with ten Health Care Assistants (HCAs) showed an understanding of the key principles of the code of rights. Resident rights/advocacy training was provided 20-Mar-12 (20 attended). Interviews with eight residents (three hospital, five rest home) confirmed that caregivers respected privacy, obtained daily consent and choice.

Criterion 1.1.1.1 Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

Audit Evidence

Attainment: FA

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.2 Consumer Rights During Service Delivery

Consumers are informed of their rights.
How is achievement of this standard met or not met?

<table>
<thead>
<tr>
<th>Criterion 1.1.2.3</th>
<th>Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Evidence</td>
<td></td>
</tr>
<tr>
<td>Finding Statement</td>
<td></td>
</tr>
<tr>
<td>Corrective Action Required:</td>
<td></td>
</tr>
<tr>
<td>Timeframe:</td>
<td></td>
</tr>
</tbody>
</table>
Criterion 1.1.2.4  Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.3  Independence, Personal Privacy, Dignity, And Respect

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1j; D4.1a; D14.4; E4.1a  ARHSS D3.1b; D3.1d; D3.1f; D3.1j; D4.1b; D14.1

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 facility provides physical, visual, auditory and personal privacy for residents. During the audit, staff demonstrated gaining permission prior to entering resident rooms. D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. Ten health care assistants (HCAs) interviewed (three dementia, three rest home and four hospital) interviewed described ensuring privacy by knocking on doors before entering. D3.1b, d, f, i  The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Resident preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities. Interview with six health care assistants described providing choice during daily cares. Interviews with eight residents (three hospital, five rest home) all stated staff provided a respectful service and were very approachable and friendly. There is an abuse and neglect policy that is implemented and staff are required to complete education on abuse and neglect. Abuse and neglect training was provided on 25-Jan-13 and 29-Jan-13 with a total of 27 staff attending. There is a competency question included in the orientation programme around abuse and neglect which staff have completed. Discussions with residents and family members were positive about the care provided.

E4.1a Three families interviewed state that their family member was welcomed into the dementia unit and personal pictures were put up and familiar items of furniture/bedding were placed in their rooms to assist them to orientate to their new environment.

Education on dignity and independence occurred 24-Apr-13 with nine staff attending. Education on Privacy was presented on 11-Mar-13 with 14 staff attending. Education on abuse and neglect occurred on 25 and 29 January 2013 with 27 staff attending.
**Criterion 1.1.3.1**  The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

<table>
<thead>
<tr>
<th>Audit Evidence</th>
<th>Attainment: FA</th>
<th>Risk level for PA/UA:</th>
</tr>
</thead>
</table>

**Finding Statement**

Corrective Action Required:

Timeframe:

**Criterion 1.1.3.2**  Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

<table>
<thead>
<tr>
<th>Audit Evidence</th>
<th>Attainment: FA</th>
<th>Risk level for PA/UA:</th>
</tr>
</thead>
</table>

**Finding Statement**

Corrective Action Required:

Timeframe:

**Criterion 1.1.3.6**  Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

<table>
<thead>
<tr>
<th>Audit Evidence</th>
<th>Attainment: FA</th>
<th>Risk level for PA/UA:</th>
</tr>
</thead>
</table>

**Finding Statement**

Corrective Action Required:

Timeframe:
Criterion 1.1.3.7  Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Audit Evidence  
**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.4 Recognition Of Māori Values And Beliefs**

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

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?**

A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). There is a range of supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as directed/requested by the resident/family/whanau. Cultural needs is addressed in the sexuality/spirituality/intimacy heading of the care plan. There is one resident in the hospital that identifies as Maori and the resident identified with the Maori care plan. D20.1i The service has developed a link with and refer residents to the ADHB Maori Health Unit Services. Cultural training has been provided for staff. The policies for Māori identify the importance of whānau and ten health care assistants from across all areas and four registered nurses discussed the importance of family involvement. There is one resident who identifies as Maori but does not choose to practice Maori culture. The residents file evidences that the resident’s culture is documented and that he does not wish to access Maori services.

Criterion 1.1.4.2 Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Audit Evidence  
**Attainment: FA**  
**Risk level for PA/UA:**
Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.4.3  The organisation plans to ensure Māori receive services commensurate with their needs.

<table>
<thead>
<tr>
<th>Audit Evidence</th>
<th>Attainment: FA</th>
<th>Risk level for PA/UA:</th>
</tr>
</thead>
</table>

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.4.5  The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

<table>
<thead>
<tr>
<th>Audit Evidence</th>
<th>Attainment: FA</th>
<th>Risk level for PA/UA:</th>
</tr>
</thead>
</table>

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.6 Recognition And Respect Of The Individual's Culture, Values, And Beliefs

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.
How is achievement of this standard met or not met?  

Attainment: PA Low

The service implements policies about recognition of individual values and beliefs. This includes cultural, religious, social and ethnic needs. Staff recognise and respond to values, beliefs and cultural differences. Values and beliefs information is gathered on admission with family involvement and is integrated into residents’ care plans.

D3.1g The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. In the dementia unit (Bob Reid) there are residents from Samoa, India and Niue. In the hospital there are residents from Sri Lanka, India and Niue.

The care plans of these residents reviewed identify their cultural, spiritual, values and beliefs. Health care assistants interviewed were able to demonstrate an understanding of each resident’s cultural needs. There are multi-cultural staff available and interviews with eight residents (three hospital, five rest home) confirmed that cultural values and beliefs were considered and discussed during preparation and review of the care plan. There is an improvement required around the documenting of residents’ spiritual needs in care plans.

A Chaplain is employed six hours per week to attend to the spiritual needs of residents.

The kitchen provides culturally specific meals for Samoan, Niue and Indian residents.

D4.1c Care plans reviewed included the resident’s social, spiritual, cultural and recreational needs.

Criterion 1.1.6.2  
The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

Audit Evidence  

Values and beliefs information is gathered on admission with family involvement and is integrated into nine of ten residents’ care plans.

Finding Statement

One resident file reviewed, did not document the resident's spiritual needs and how these affected other aspects of care.

Corrective Action Required:

Ensure care plans address the spiritual needs of residents

Timeframe:

3 months

STANDARD 1.1.7  Discrimination

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS  D16.5e
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

Staff employment policies/procedures include confidentiality, house rules and staff expectations. Code of conduct policies also include respect for personal belongings. Job descriptions include responsibilities of the position. Signed copies of all employment documents are included in staff files. Three registered nurses interviewed were able to describe appropriate boundaries between staff and residents and their families. Interviews with eight residents (three hospital, five rest home) confirmed that staff were very caring.  

D16.5e: Health care assistants are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with ten health care assistants (HCAs) interviewed (three dementia care, three rest home and four hospital) could describe how they build a supportive relationship with each resident.

Criterion 1.1.7.3  

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

Audit Evidence  

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.8  

Good Practice

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c  ARHSS A2.2; D1.3; D17.2; D17.10c

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

Ranfurly Care Limited has quality and risk management systems and these are implemented at the facility supported by a number of meetings held on a regular basis including (but not limited to); quality, general staff, IC, restraint, residents, RNs, kitchen, health and safety. Comprehensive policy/procedures are well established, cross referenced and implementation is supported by way of a robust education programme. Extensive annual education programme in place, including internal and external education sessions, core competency assessments and orientation programmes have been implemented. The Education and Health and Safety Officer (physiotherapist) is focused on targeted training including staff one–on-one. Competencies are completed for key nursing skills, registered nurses regularly access training and are supported to complete PDRP at the DHB.
All staff are encouraged to take post graduate studies and engage in external training. There is a strong commitment to staff development by way of education and in-service training. Education is supported for all staff and a number of health care assistants have enrolled or completed a national qualification. Implementation of evidenced best practice and legislation requirements are reflected in clinical policies. Ranfurly Care Limited has a number of quality projects running including; falls prevention project, pressure area care, targeted training through needs identified by the registered nurses and care manager. Registered nurses have been encouraged and supported to take on additional leadership roles and responsibilities such as Advance Life Care planning coordinator, quality coordinator, Liverpool care pathway resource nurse specialist, continence promotion and dementia service leader. Care planning is holistic and integrated. Quality Improvement alerts are identified to minimise potential risks occurring and the facility is required to complete an action plan. Ranfurly Care Limited is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and complaints.

A2.2 Services are provided at Ranfurly Care Limited that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring.

D1.3 all approved service standards are adhered to.

D17.7c There are implemented competencies for care workers and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

---

### Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.

<table>
<thead>
<tr>
<th>Audit Evidence</th>
<th>Attainment: FA</th>
<th>Risk level for PA/UA:</th>
</tr>
</thead>
</table>

#### Finding Statement

#### Corrective Action Required:

#### Timeframe:

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### STANDARD 1.1.9 Communication

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; D16.53.i.3.iii; D20.3

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
Full information is provided at entry to residents and family/whānau. Families are involved in the initial care planning and in on-going care and regular contact is maintained with family including; if an incident/accident, care/medical issues or complaints arise. Registered nurses demonstrated their responsibility to notify family/whānau of any incident/accident that occurs and contact with family/next of kin is recorded. D16.4b Relatives (four hospital, two rest home, three dementia care) stated that they are always informed when their family members health status changes. Access to interpreter services is identified as through Auckland DHB. This includes language support, the DHB, Hearing Association and the Blind Foundation. Ranfurly Care Limited has multi-cultured staff and residents, registered nurses and caregivers described being able to interpret for some residents when needed.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.

D11.3 The information pack is available in large print and advised that this can be read to residents.

D16.1bii; The information pack and admission agreement included payment for items not included in the services. A site specific Introduction to Dementia unit booklet providing information for family, friends and visitors visiting the facility is included in the enquiry pack along with a new residents handbook providing practical information for residents and their families.

Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.

<table>
<thead>
<tr>
<th>Audit Evidence</th>
<th>Attainment: FA</th>
<th>Risk level for PA/UA:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finding Statement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrective Action Required:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timeframe:</td>
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</tr>
</tbody>
</table>

Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.

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**STANDARD 1.1.10 Informed Consent**

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1  ARHSS D3.1d; D11.3; D12.2; D13.1

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:** PA Low

Ranfurly Care Limited has policies in place for advanced care planning, informed consent and resuscitation. The service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights.

Six of ten resident files included appropriately signed resuscitation forms, general consent forms and evidence that advance directives are actively discussed with residents and family. Therefore an improvement is required.

Discussions with four registered nurses identified that staff were familiar with advanced directives and the fact that only the resident (deemed competent) could sign the advance directive.

D13.1 there were ten admission agreements sighted and all had been signed on the day of admission

D3.1.d Discussion with nine family identified that the service actively involves them in decisions that affect their relatives lives.

### Criterion 1.1.10.2  
Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

### Criterion 1.1.10.4  
The service is able to demonstrate that written consent is obtained where required.
Audit Evidence: Attainment: FA  Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.10.7  Advance directives that are made available to service providers are acted on where valid.

Audit Evidence: Attainment: PA  Risk level for PA/UA: Low

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.11  Advocacy And Support

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e  ARHSS D4.1e; D4.1f

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

Advocacy information is part of the service entry package and is on display on noticeboards around the facility. The right to have an advocate is discussed with residents and their family/whānau during the entry process and relative or nominated advocate is documented on the front page of the resident file. Advocacy services staff training has occurred for staff annually. Interviews with eight residents (three hospital, five rest home) confirmed that they are aware of their right to access advocacy.
D4.1; Discussion with relatives (four hospital, two rest home, three dementia care) members identified that the service provides opportunities for the family/EPOA to be involved in decisions.

D4.1e, The resident file includes information on resident’s family/whānau and chosen social networks

**Criterion 1.1.11.1 Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.**

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**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources**

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e  ARHSS D3.1h; D3.1e; D16.5f

Evaluation methods used: D ☒  SI ☐  STI ☐  MI ☐  Cl ☐  Mal ☐  V ☐  CQ ☐  SQ ☐  STQ ☐  Ma ☐  L ☒

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

Attainment: FA

The service has a policy maintaining links with family and community, identifies assistance with the electoral process and visiting arrangements that are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Residents are supported by activity staff to access the community as required and the service maintains key linkages with other community organisations.

D3.1h; Discussion with relatives (four hospital, two rest home, three dementia care) confirm that they are encouraged to be involved with the service and care.

D3.1.e; Discussion with staff across the facility and nine relatives report that residents are supported and encouraged to remain involved in the community and external groups such as church visits, own GP and shopping.

**Criterion 1.1.12.1 Consumers have access to visitors of their choice.**

| Audit Evidence | Attainment: FA | Risk level for PA/UA: |
**Finding Statement**

Corrective Action Required:

Timeframe:

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**Criterion 1.1.12.2** Consumers are supported to access services within the community when appropriate.

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**Finding Statement**

Corrective Action Required:

Timeframe:

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**STANDARD 1.1.13 Complaints Management**

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

| Evaluation methods used: D □  S[ ]  S[ ]  S[ ]  M[ ]  C[ ]  M[ ]  V[ ]  C[ ]  S[ ]  S[ ]  S[ ]  M[ ]  L[ ] |

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

The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights. D13.3h. a complaints procedure is provided to residents within the information pack at entry. The complaints register for 2013 (five written and twenty-six verbal) were tracked, indicating that they had been actioned according to investigation/follow-up letter timeframes and all but one complaint identified resolution. The complaint reviewed which did not document if resolution has been achieved to the satisfaction of the complainant has been waiting for a response from the complainant since February 2013. Attempts to follow up on this complaint were evidenced. The staff and quality meetings identified discussion of complaints and outcomes. Discussion with eight residents and nine relatives confirmed they were provided with information on complaints and complaints forms.
E4.1biii. There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.

Criterion 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.

Audit Evidence

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Audit Evidence

Finding Statement

Corrective Action Required:

Timeframe:

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 Mal V CQ SQ STQ Ma L |

| How is achievement of this standard met or not met? | Attainment: FA |

There is a quality and business plan 2013. The Quality Plan is divided into a number of sections including, consumer rights, quality and risk management (which includes infection control and health and safety), restraint minimisation, service delivery, education and training, work place culture and dementia specific objectives. Ranfurly Care Limited provides hospital - medical, geriatric, rest home and dementia level care for up to 129 residents across three units. There were 45 rest home residents and 31 hospital residents and 24 residents receiving dementia level care at the time of audit. The service has decommissioned 17 rest home beds in the older part of the building which needed repairs as the service is in the process of building a purpose built facility on site which will be ready later this year. The General Manager (RN) is supported by the Care Manager (RN). There are job descriptions for both positions that include responsibilities and accountabilities. A quality coordinator (RN) and an educator and health and safety coordinator (physiotherapist) are part of the management team. ARC,D17.3di (rest home), D17.4b (hospital), the General Manager (RN) has maintained at least either hours annually of professional development activities related to managing a hospital.

**Provisional**

Ranfurly Village Limited (RVL) purchased a lease from Ranfurly Veteran Care Limited in October 2012 and the rights to develop the site. Ranfurly Village Limited also took over the operation of the aged care services in October 2012. RVL established the legal entity Ranfurly Care Limited to operate the aged care services. RVL has built a new Aged Care Facility (Ranfurly Care and Veteran Facility) on vacant land on the current site and all existing residents will be transferred form the old facility to the new facility in late October 2013. The area the current aged care services are operating from will then be demolished for the village to be built. The bank financing the village development has requested a change to the lease arrangements and the new Aged Care Facility is required to be subdivided off from the Village development and run by a separate legal entity.

The new legal entity has been incorporated and Ranfurly Village Hospital Limited will run the aged care services. RCL will transfer over all operating systems, policies, procedures and intellectual property to Ranfurly Village Hospital Limited. All staff will be offered the opportunity to transfer employment from RCL to Ranfurly Village Hospital Limited. We will not have any change to key personnel. The governance and management structures will remain the same.

No changes will occur to the current organisational structure. The current structure will transfer from Ranfurly Care Limited to Ranfurly Village Hospital Limited. There will be no changes to key personnel, organisational management, or clinical management/leadership staff.
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

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Finding Statement

Corrective Action Required:

Timeframe:

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.

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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

During a temporary absence, the care manager covers the general manager's role. The service is supported by the Company Director. The service has an education and health and safety coordinator and quality coordinator. D19.1a; a review of the documentation, policies and procedures and from discussion with staff identified that the
service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. There is a quality and business plan 2013 which includes consumer rights, quality and risk management (which includes infection control and health and safety), restraint minimisation, service delivery, education and training, work place culture and dementia specific objectives.

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 1.2.3 Quality And Risk Management Systems
The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.
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
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
Ranfurly Care Limited has an established quality and risk management system. Interviews with staff and review of meeting minutes/quality reports demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings, through the communication book, and also to the trust board.
The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. All quality manuals can be accessed on line. Staff have been provided with education on how to access the quality manuals and educational resources. Computer education for staff occurred on 21-Apr-13 with 16 staff attending. The policies and procedures have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. Discussion regarding policy development/revision occurs at staff meetings. Release of updated or new policy/procedure/audit/education occurs across the facility (sighted). Key components of the quality management system link to the monthly quality reports provided from departments. There are monthly accident/incident reports completed by the quality coordinator that
break down the data collected across the rest home, dementia and hospital units and staff incidents/accidents. The complaints process is linked to the quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Complaints are included in the GM monthly report to the Company Director.

The monitoring programme includes (but not limited to); environment, kitchen, medications, care and hygiene, documentation, moving and handling, code of rights, weight management, H&S, accident reporting documentation, care planning and infection control. Frequency of monitoring is determined by the internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee e.g. quality. The service is active in analysing data collected and corrective actions are required based on audit outcomes. Feedback is provided via graphs and reports.

Quality action forms are utilised and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. Reports provided to the monthly quality meeting (such as health and safety and infection control) include areas identified for improvement and actions initiated.

D19.3: There is a comprehensive H&S and risk management programme in place. Hazard identification, assessment and management policy guides practice. The 2013 quality plan includes a project around staff fitness and health.

D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, review of medication with GP, hi/lo beds, assessment and exercises by the physiotherapist, and sensor mats.

### Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.

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**Corrective Action Required:**

**Timeframe:**

### Criterion 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.

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Criterion 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.

Audit Evidence  
Finding Statement

Criterion 1.2.3.5  Key components of service delivery shall be explicitly linked to the quality management system.

This shall include, but is not limited to:

(a)  Event reporting;
(b)  Complaints management;
(c)  Infection control;
(d)  Health and safety;
(e)  Restraint minimisation.

Audit Evidence  
Finding Statement
Corrective Action Required:

Timeframe:

**Criterion 1.2.3.6**  
Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

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Corrective Action Required:

Timeframe:

**Criterion 1.2.3.7**  
A process to measure achievement against the quality and risk management plan is implemented.

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**Criterion 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.

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Corrective Action Required:

Timeframe:

Criterion 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.

Audit Evidence  Attainment: FA  Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.4  Adverse Event Reporting

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

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

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
D19.3c: The service collects incident and accident data.
D19.3b: The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. Minutes of the quality meetings and H&S meeting reflect a discussion of results.

A sample of twenty incident forms reviewed for June 2013 identified incident forms were fully completed and included the treatment/assistance given, and preventative actions to be implemented (where appropriate) and documented contact with family.

One event (a sudden death) which occurred in October 2012 was investigated by the Coroner. Letter from medical officer and investigation of the incident was sighted. A letter from the medical officer dated 07-Nov-12 (sighted) reports the staff acted very competently.

Discussions with the general manager and care manager, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. Outbreak management plan sighted documented Public Health and DHB were notified of an outbreak of diarrhoea and vomiting in June 2013.

Criterion 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.

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Criterion 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.

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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

A register of registered nurses' practising certificates is maintained. Website links to the professional bodies of all health professionals have been established and are available on the computers and in training folder.

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Ten files reviewed files (two registered nurses, one care manager, one quality coordinator, one cleaner, three caregivers, cook, diversional therapist) and all had up to date performance appraisals. All staff files included a personal file checklist.

The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. New staff are buddied for a period of time. The length of time each new staff member is "buddied" is dependent on past experience and qualifications but a minimum of three days- one month for health care assistants and RNs four weeks. During this period they do not carry a clinical load. Completed orientation booklets are on staff files. Staff interviewed (four registered nurses and ten HCAs) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. One registered nurse interviewed had recently commenced employment at the facility and reported that the orientation process was thorough, with on-going support being provided by the care manager, education and health and safety co-ordinator, and GM.

In 2012 it was noted that staff attendance at staff training was low. As a quality improvement project around ways of improving staff attendance were discussed with staff. All staff now have access to the quality manuals and educational resources on line. If staff are unable to attend an education session they are able to access the hand outs via the online educational resources at Ranfurly Care Limited.

Interviews with the Education and health and safety coordinator confirmed that HCAs when newly employed complete an orientation booklet. There is an annual education schedule that is being implemented. External education is available via the DHB. There is evidence on RN staff files of attendance at the RN training day/s and external training.

Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Education is an agenda item of the staff meetings.

A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training. D17.7d: RN competencies include; assessment tools, BSLs/Insulin admin, CD admin, moving & handling, nebuliser, oxygen admin, PEG tube care/feeds, restraint, wound management, CPR, and T34 syringe driver.
There are 19 staff who have completed ACE dementia education modules. Both the RN and EN working in the dementia unit have also completed ACE dementia modules. There is one staff member currently completing ACE dementia education who has commenced employment in the dementia unit within the last six months. Fifteen HCAs have attained National Certificates in Support of the Older Person.

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<th>Criterion 1.2.7.2</th>
<th>Professional qualifications are validated, including evidence of registration and scope of practice for service providers.</th>
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<th>Criterion 1.2.7.3</th>
<th>The appointment of appropriate service providers to safely meet the needs of consumers.</th>
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<th>Criterion 1.2.7.4</th>
<th>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</th>
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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 [ ] Mal [ ] V [ ] CQ [ ] SQ [ ] STQ [ ] Ma [ ] L [ ]

How is achievement of this standard met or not met?  Attainment: FA

There is a charter in place which includes standards of care and minimum staffing levels. The charter specifically outlines hours per resident per day numbers for registered nurses and health care assistants. These staffing levels adhere to best practice guidelines and are compliant with the aged related residential care agreement. There is good registered nurse cover. Nursing/caring hours per resident day for the various client groups are documented. There is a rest home unit and hospital unit in the main building and the dementia unit is in a separate building. There is a care manager (registered nurse) who works Monday-Friday 40 hours per week. The service provides 24 hr RN cover. Interviews with relatives and residents all confirmed that staffing numbers were good. HCAs and registered nurses interviewed stated that staffing ratio to residents is good, that they have input into the roster and management were supportive around change when times are busier.
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.

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Audit Evidence  

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STANDARD 1.2.9 Consumer Information Management Systems

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1  ARHSS A15.1; D7.1; D8.1; D22

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 resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is also developed in this time.

Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a secure locked filing cabinets at the nurses’ station in each unit/department. Archived files are kept in a secure storage area in the administration office. Care plans and notes are legible and signed and dated by relevant staff with designation documented. Policies contain service name. All resident records contain the name of resident and the person completing the entry.

Individual resident files demonstrate service integration. There is an allied health section that contains general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.

Criterion 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

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Risk level for PA/UA:
Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.7  Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Audit Evidence  
Attainment: FA  
Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.9  All records are legible and the name and designation of the service provider is identifiable.

Audit Evidence  
Attainment: FA  
Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.10  All records pertaining to individual consumer service delivery are integrated.

Audit Evidence  
Attainment: FA  
Risk level for PA/UA:
**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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**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 1.3.1 Entry To Services**

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b     ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

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

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<td>The care manager and RNs are responsible for the screening of residents to ensure entry has been approved. The four RN's interviewed were able to describe the admission process. NASC approvals for entry are required. An information booklet is given out to all residents/family/whanau on enquiry or admission. The information pack includes all relevant aspects of service and associated information such as the H&amp;D Code of Rights and how to access advocacy. The CM/RN on duty completes all the admission documentation and relevant notifications of entry to the service. A clinical admission checklist and resident orientation checklist is completed. Four hospital, two rest home and three dementia care families interviewed state they received adequate information on the services and the admission process. Six week post admission surveys are sent out and were evidenced completed. E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on: 1. Minimising restraint. 2. Behaviour management. 3. Complaint policy. D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract in ten of ten files sampled. D14.1 exclusions from the service are included in the admission agreement.</td>
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D14.2: the information provided at entry includes examples of how services can be accessed that are not included in the agreement
E3.: three resident files were reviewed and all includes a needs assessment as requiring specialist dementia care

**Criterion 1.3.1.4** Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

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**STANDARD 1.3.2 Declining Referral/Entry To Services**
Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2
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 has an accepting/declining entry to service policies. Ranfurly Care Limited provide three levels of care, rest home, hospital and dementia level care. The care manager stated that entry to the service would be declined if there were no beds available. The care manager would refer the client back to the referrer for other options available and record the declined entry details.

**Criterion 1.3.2.2** When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

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STANDARD 1.3.3 Service Provision Requirements
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

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?

**D.16.2, 3, 4:** The 10 resident files sampled (four hospital, three rest and three dementia care) identified that the RN completed an initial assessment within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial RN assessment. A Lifestyle diary is displayed inside the residents wardrobe for the health care assistants (HCA’s) to readily access care information about resident mobility and continence needs. All 10 files sampled identified that the long term care plan is developed within three weeks. There is documented evidence in 10 of 10 resident files sampled of multidisciplinary reviews held six monthly. Allied health professionals involved in the residents care are linked to the long term care plan review such as, dietitian, physiotherapist, podiatrist, hospice and community mental health nurse. The resident records include resident details and next of kin, admission documentation, care plan documents, medical notes, allied health notes, nursing progress notes, accident incident log, infection management log, referrals and correspondence. The resident records evidence an integrated team approach.

Resident (where appropriate) /family/whanau participation is evident in the development of the initial assessment and review of the long term care plans in sample of resident files reviewed. Relatives (four hospital, two rest home, three dementia care) confirmed they are involved in the care planning process. All 10 resident files included a family/whanau communication recording sheet which documented discussions with family/whanau regarding changes to health, incidents, infections, MDT meetings and GP visits.

Families interviewed (four hospital, two rest home, three dementia) state they are satisfied with the level of support their relative receives.

**D16.5e:** 10 of 10 resident files sampled identified that the GP had seen the resident within two working days. There is a GP review three monthly and more frequent visits are evidenced in the medical notes for residents of residents with more complex conditions or acute changes to health status. Two GP's interviewed provide 24/7 medical services for their residents. The GP's visit daily Monday to Friday. Current APC's sighted. Both GPs interviewed state they are involved in the six monthly MDT review. Families are invited and the GP is able to discuss the resident’s medical condition, changes, referrals, and any concerns with the family. RN's notify the GP's promptly of any concerns. One GP stated the RN's are experienced with good clinical judgement.
A range of assessment tools are available for risk assessments on admission and reviewed at least six monthly or earlier if applicable including (but not limited to); a) nutritional profile  b) falls risk assessment (reference to Norton/Tinetti )  c) berg balance assessment. d) waterlow pressure area risk assessment e) continence. assessment  f) MME (mini mental examination) and g) behaviour assessment  h) pain assessment

A physiotherapist is on-site for 24 hours a week and carries out resident assessments and prescribes therapy. The physiotherapist completes an assessment on admission (Berg balance) which is included as part of the residents long term care plan. The physiotherapist is involved in the MDT review six monthly. She has  physiotherapy assistants who follows up treatment plans and exercise plans. There is a designated physiotherapy room which is available for residents to visit and do some exercises when the physiotherapist/physiotherapy assistants are on site. The physiotherapist also provides training and education for staff on safe transferring techniques and the use of transferring equipment.

The podiatrist visits for a full day every six weeks.

A dietitian is available as required for advice and management for at risk residents with unintentional weight loss.

The Community Mental Health Nurse (CMHN) with the Mental Health services for the older person visited the dementia care unit during the audit. The CMN has been with the service for 10 years. The CMHN interviewed stated that each keyworker (occupational nurse or CMHN) has a caseload. If the client is admitted to dementia care from the community they follow up the resident for a period of time within the dementia care unit then discharges the client from the service if appropriate. The CMHN can be readily accessed by a referral fax/phone call for urgent matters during the daytime on weekdays. The CMHN stated that the service provides best care for their residents and in particular for the island/ethnic groups, and praised the staff for the individual care and attention the residents received. Clients settle fairly quickly into the environment within the Bob Reed unit. The three dementia care relatives interviewed confirm that their family member has settled into the environment and are complimentary of the care delivered and service provided.

Handovers occur at the beginning of each shift for all the team within each of the units... There is a verbal handover and written shift notes detailing any changes to care, significant events, infections, incidents. Progress notes are maintained in the residents files sampled (four hospital, three rest home and three dementia care)

Clinical staff have undertaken education and training in all areas of clinical care such as safe handling of residents, use of mobility aids including hoists, dementia care and challenging behaviour, falls management, palliative care and other medical conditions. The RN's attend DHB study days as offered.

Hospital resident files sampled, Rest Home resident files sampled, Dementia resident files sampled.

Tracer Methodology: Rest home resident

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

Tracer Methodology: Hospital resident

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

Criterion 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.

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Finding Statement
Criterion 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.

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Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

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STANDARD 1.3.4 Assessment
Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.
**How is achievement of this standard met or not met?**

Admission documentation obtained on interview with resident/relative or advocate includes (but not limited to): personal and next of kin identification, ethnicity and religion, current and previous health and/or disability conditions, medication and allergies, informed consents for photograph, name on bedroom door, giving out health information to relevant personnel, nominated contact person to be informed of any change in residents health status and consent for outings/appointments are obtained within a timely manner. Information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies is gathered by the RN to develop the initial assessment and care plan within the required timeframes. The RN and DT complete a social and cultural assessment that includes family, background, language and which armed forces they were in during the war, the area they served in and if they became a prisoner of war and does the resident suffer for any "flash backs" to the war. There is an occupational therapy/DT assessment that covers any relevant medical or disability information, problems or equipment needed to achieve daily activities of living, social/psychological skills, cognitive skills, sensory motor skills, neuromuscular/motor skills and any other relevant information. The RN initial assessment covers cognitive and behaviour assessment, personal hygiene and grooming, communication, sleep, elimination, nutrition, skin assessment and body map, pain assessment, respiratory and circulatory assessment, pain, personal safety and a physiotherapy assessment.

All resident files sampled (four hospital, three rest home and three dementia care) evidenced an initial assessment and care plan with reference to the information gathered on admission. Residents and their family participate in the initial assessment and care plan and this information is available to other health professionals as needed. Relatives (four hospital, two rest home, three dementia care) and residents (three hospital, five rest home) advised on interview that assessments were completed in the privacy of their room or private area.

A range of assessment tools are available for risk assessments on admission and reviewed at least six monthly or earlier if applicable including (but not limited to); a) nutritional profile b) falls risk assessment (reference to Norton/Tinetti ) c) berg balance assessment. d) waterlow pressure area risk assessment e) continence. assessment f) MME (mini mental examination) and g) behaviour assessment h) pain assessment i) wound assessment (if applicable). Wound treatment forms are in place that describe the dressing type, intervention and evaluation of the healing process.

A continence product requirement form is used where day and night products are required. There is an improvement required around the use of assessment tools for wounds and incontinence problems.

ARC E4.2; Three dementia care resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements however the individual recreational plan did not cover the 24 hour period. There is a requirement to develop an individual 24 hour recreational plan for residents in the dementia care unit.

E4.2a Challenging behaviours assessments are completed.

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**Audit Evidence**

Wound assessments were evidenced completed for seven of eleven wounds.

**Finding Statement**
There are no wound assessments for four chronic wounds in the rest home. b) There is no evidence of continence assessments for two hospital and two dementia care residents with incontinence problems identified on admission c) The individual recreational plan for residents in the dementia unit did not cover the 24 hour period.

**Corrective Action Required:**
a) Ensure that wound care assessments are completed for all wounds b) ensure continence assessments are completed for residents with identified incontinence problems and c) ensure that individual recreational plans are completed to cover a 24 hour period.

**Timeframe:**
3 months

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**STANDARD 1.3.5 Planning**

Consumers’ service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

**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 individual care plan is developed by the RN and describes the residents identified needs, goals and interventions with dates and signatures. The care plan includes the following needs: social and cultural, personal hygiene and grooming, communication, sleep, nutrition, elimination, skin, pain, respiratory and circulation, personal safety and physiotherapy assessment. There is an evaluation page with each identified need. Baseline observations of blood pressure, pulse and weight are recorded on admission. Continuing needs assessment are carried out by an RN. The care plans identify links to allied health professionals involved in the care of the resident. The family/whanau communication recording sheet in ten of ten files sampled evidences invitations to families to attend the six monthly review of the care plan. Residents/families interviewed confirm they participate in the care planning process. The four RN's interviewed are knowledgeable in the care planning requirements. Care plans sighted in 10 of 10 resident files are current. Short term care plans are used for short term or acute needs. Short term care plans in use are for dry skin, medication change for Parkinson's, chest infection, increased falls, ESBL in urine, lesion and weight reduction.

E4.3 Three resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.

D16.3k, Short term care plans are in use for changes in health status.

D16.3f; 10 if 10 resident files reviewed identified that family were involved.

---

**Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.**

**Audit Evidence**

Attainment: FA

Risk level for PA/UA:
Criterion 1.3.5.3  Service delivery plans demonstrate service integration.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.6  Service Delivery/Interventions

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

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

Residents' long term care plans are completed by the registered nurses. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. The ten health care assistants (HCAs) interviewed (three dementia care, three rest home and four hospital) from the morning and afternoon shifts stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including hoists, electric beds, pressure relieving mattresses and cushions, shower chairs, transfer belts, wheelchairs, gloves, aprons and masks.

D18.3 and 4. All staff report that there are always adequate continence supplies and dressing supplies. Supplies of continence and wound care products were sighted in each treatment room. (link 1.3.4.2). Four RN's interviewed could describe the referral process for wound and continence nurses. USL medical are available for education and advice regarding the incontinent products.
Palliative care is delivered with support from Mercy Hospice nurses and specialists as required. Liverpool care pathway is implemented and medications for pain relief and comfort is kept in the hospital unit CD safe. RN's are medication competent in the use of the syringe driver and attend education at the hospice on pain management and end of life care.

The rest home has access to the hospital hoist if required for falls. The dementia care unit has a hoist which is readily accessible. All falls are recorded on the accident/incident form. Corrective actions are implemented including a review of the falls risk assessment, closer observation, hip protectors, physiotherapy referral and a review of mobility status and mobility aids required. The HCA's sign a hip protector checklist daily that ensures residents are wearing their hip protectors.

Residents are weighed monthly and any resident with unacceptable or unintentional weight loss is placed on nutritional plan and or referred to the dietitian or GP.

Emergency equipment (oxygen and suction) is available and have been checked/calibrated. There is an emergency collapse kit readily accessible. Monitoring forms are put in place where there has been an identified need or following GP specific instructions for monitoring, such as blood sugar levels, blood pressure, bowel charts, food and fluid, behaviour monitoring, weight monitoring and restraint monitoring.

Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Audit Evidence

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.7 Planned Activities

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

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

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 qualified DT works 75 hours a fortnight in the rest home area and the Activities co-ordinator works 70 hours a fortnight between the hospital and dementia care units. The Occupational therapist has recently resigned and the Care Manager is now overseeing the activities team. The DT is a member of the west Auckland support group and attends meetings and workshops two monthly. Networking occurs within the DT Society and there is access to information that is shared with the team. The DT and RN complete the cultural and social part of the assessment and care plan for new residents. The activities team is included in the MDT meeting with the resident/family to evaluate the care plan and goals. The DT/Activities co-ordinator record resident's participation in group and individual activities in their progress notes. Attendance records are maintained. A quality initiative recently implemented by the team is called a "What's on" programme. There are separate activity programmes developed for each unit. The programme is planned to allow for residents to be able to attend/choose an activity/entertainment in another unit. A weekly "What's on" programme is displayed in large print in each of the units and staff are able to inform residents as to "What’s on" and direct/supervise them to attend the activity of choice. The team meets weekly with the care manager to review and evaluate the weekly programme. Some of the activities across the site includes craft, board games, ball games, snooker (table in the recreation room), baking, gardening club, ladies afternoon. The men have a "man cave" which is a separate lounge and TV and activities are arranged in consultation with the men. A volunteer takes yoga each week and takes residents for walks in the gardens. The physiotherapist is involved in the physical aspect of the programme to ensure residents remain safe and the exercises meet the physical abilities of the residents. Entertainers are scheduled weekly and there are a variety of musical entertainers and guest speakers including Age concern and SPCA. Residents enjoy the school children visiting. The home does not have its own vehicle and hire a wheelchair van that seats 12 residents and two staff. The DT and Activities co-ordinator hold current first aid certificates. Residents attend the RSA lunches fortnightly and enjoy outings to Devonport Naval Museum, the airport and shopping trips. Resident choice to participate is respected. Many hospital level residents participate passively in the activity taking place in the lounge. On the day of audit the residents in the dementia care unit enjoyed a lunch of fish and chips from the newspaper wrapping and a beer or soft drink.

Feedback on the programme is received through the resident meetings two monthly and resident surveys. An improvement identified is for more one on one contact with those residents who do not participate in group activities. The activity team has commenced meeting with residents/families individually to complete life histories and develop an individual activity plan with goal setting. As part of the project plan there is a requirement for residents in the dementia care unit to have individual activity plans to cover a 24 hour period. (link 1.3.4.2)

D16.5d Resident files reviewed identified that the cultural and social part of the residents individual activity plan is reviewed the long term care plan review with the MDT.

Criterion 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.

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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 ☑️ Mal ☐ V ☑️ CQ ☑️ SQ ☑️ STQ ☐ Ma ☐ L ☑️

How is achievement of this standard met or not met?

Attainment: FA

The RNs complete a six week admission review and updates the care plan as necessary. Six monthly evaluations occur and families are phoned and invited to attend the MDT (multidisciplinary) review. Those present at the MDT review include the GP, RN, Activities/DT, physiotherapist and resident/family.

The nursing care plan and social cultural assessment (activity care plan), resuscitation status, medications, laboratory results are reviewed and meeting minutes list any areas to address. MDT meeting minutes for individual residents sighted with areas to address signed as being completed.

The RNs amend the long term care plan to reflect on going changes as part of the review process. Care plans are evaluated more frequently when clinically indicated.

D16.4a Seven out of ten care plans are evaluated six monthly. Three residents had not been at the service long enough for a six monthly evaluation.

ARC: ARHSS D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.

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

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.
STANDARD 1.3.9  Referral To Other Health And Disability Services (Internal And External)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4  ARHSS D16.4c; D16.4d; D20.1; D20.4

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?

Referral to other health and disability services is evident in sample group of resident files. The service facilitates access to other medical and non-medical services. Examples of referrals sighted were to Needs assessment service, physiotherapist, speech language therapist, occupational therapist, ACC, radiology, social worker, eye clinic, ophthalmologist, specialist haematologist, diabetic photo screening, mental health services for the older person, community palliative care specialist, gerontology nurse specialist, oncology, urology, orthopaedics, renal specialist, consultant psychiatrist.

The service also make contact with the War pensions office on behalf of the resident as required. Families are notified of any referrals required and the GP discusses options for treatment as evidenced in the GP medical notes. Referral forms describe the assessment/treatment request for the resident, date referral actioned, outcome and recommendations. Referral documentation is maintained on resident files.

D16.4c; the service provided an examples of where a residents condition had changed and the resident was reassessed for a higher level of care. Referral sighted.

D 20.1 discussions with registered nurses identified that the service has access to the dietitian, physiotherapist, mental health services for the older person, speech language therapist, dental care, diabetes nurse, continence and wound nurses, hospice.

Criterion 1.3.9.1  Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.
STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21  ARHSS D21

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 RN's interviewed described the document and nursing requirements as per the policy for discharge and transfers. The documentation required includes resident transfer form and yellow envelope checklist. Additional relevant information is copied such as the Resuscitation status, progress notes, laboratory results, nutritional needs form, progress notes, medical notes. A GP or RN letter is sent to the emergency department with the resident. The family are notified and if unable to accompany the resident to hospital a nursing escort is provided. There is an escort reporting form that is filled out by the attending medical professional and returned to the RN on duty. This form is also used when families escort their relative to appointments. Completed documentation is evident for a recent discharge from hospital to the facility. Internal transfer documentation from rest home care to hospital level is sighted in residents records. The family are informed of any transfers. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.

Criterion 1.3.10.2  Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.
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: PA Low

There are medication policies and procedures that cover each stage of medicine management. Medication trolleys are kept in locked rooms in the hospital, rest home and dementia care unit. The supplying pharmacy delivers the robotic rolls which are checked and signed by the nightshift RN. Any discrepancies are fed back to the pharmacy. Returns to the pharmacy are stored safely until collected. The pharmacist conducts three monthly audits on the medication charts and six monthly audits on the controlled drugs. RN's only administer medications and are competency assessed for the administration of oral, controlled drugs and subcutaneous medications. Medication education is attended annually. RN's have syringe driver competency and attend annual refreshers at Mercy Hospice. Controlled drugs (CD's) are delivered in medico packs. The hospital controlled drug safe holds the CD's for the hospital and dementia unit. The CD register is checked weekly by two RN's (sighted). One RN signs for the administration of controlled drugs. The hospital unit holds the Liverpool care pathway medications. The rest home has a controlled drug safe and the CD register is checked weekly by two RN's (sighted). Telephone orders are taken from the GP's if necessary. The two GP's have standing orders in place that are current, indicate a reason for use and have an administration timeframe of 48 hours for the listed standing orders. The locked medication trolleys (two hospital, one rest home and one dementia care medications outside of the expiry date. Eye drops are dated on opening. There are no self medicating residents. Each unit has a medication fridge. The temperatures are recorded weekly in the hospital and rest home units. The hospital fidge has three consecutive weeks of temperatures at 0 degrees Celsius. The rest home fridge has eight consecutive weeks of temperatures at 10 degrees Celsius. There is one temperature recording only for the dementia unit fridge since March-13. There is no corrective action taken for temperatures outside of the acceptable range. The temperature recording format corrected on the day of audit includes the acceptable temperature range and corrective action to be taken for temperatures outside of the acceptable range. There is a weekly nightshift checklist that includes the glucometer, oxygen cylinders and pharmaceutical supplies. The medication folder contains information on the MOH medication administration guidelines. Administration signing sheets are correctly signed with the time given for PRN medications. Eight hospital, six rest home and six dementia care medications charts sampled have photo identification and allergies/adverse reactions noted. There are alert stickers for allergies and sensitivities and duplicate name. Special instructions and precautionary notes are made on the medication chart. The medication charts are legible, dated, signed by the GP and reviewed three monthly by the GP. The GP has no route of the medication prescribed in 20 of 20 medication charts and no indication for use of PRN medications in 14 of 20 medication charts.

Oxygen cylinders, oxygen concentrator and suction is available in the event of an emergency. There is an emergency box for sudden collapse. Emergency drugs such as diazepam, adrenaline and frusemide are readily available for GP to administer or RN (under GP instructions) Oximeter and blood pressure recording equipment (calibrated Nov-12) is available. All RN's have current first aid certificates.

D16.5.e.i.2; 20 medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed.
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: PA  Risk level for PA/UA: Low

Each unit has a medication fridge. The temperatures are recorded weekly in the hospital and rest home units. The medication charts are legible, dated, signed by the GP and reviewed three monthly by the GP. Six of 20 medication charts reviewed documented the indication for use of PRN medications.

Finding Statement

(a) The hospital fridge has three consecutive weeks of temperatures at 0 degrees Celsius. The rest home fridge has eight consecutive weeks of temperatures at 10 degrees Celsius. There is one temperature recording for the dementia unit fridge since March-13. There is no corrective action taken for temperatures outside of the acceptable range.
(b) There is no route of medication administration prescribed in 20 of 20 medication charts and no indication for use of PRN medications in 14 of 20 medication charts.

Corrective Action Required:

a) Ensure there is a route of medication prescribed and the indications for use of PRN medications is documented on medication charts by the GP. b) Ensure that medication fridge temperatures are recorded and any reading outside the optimum range are reported and corrective action completed.

Timeframe: 3 months

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
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

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 Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met? Attainment: FA

The food services are contracted out to Medirest (Compass). The on-site kitchen manager/chef oversees the food service. There is an early morning cook from 6am. The cook is supported by a morning and afternoon kitchen hand. The kitchen manager/chef is on site Monday to Friday 9am to 6pm. There is a weekend chef/reliever. The chefs are qualified and the kitchen staff have attended food safety and hygiene and chemical safety through Compass. The staff attend team training monthly that covers the food services programme, infection control and health and safety. There is a four weekly seasonal menu reviewed by the Medirest national dietitian. The dietitian is readily accessible by phone and visits the site as required. The kitchen receive the residents dietary profile and any changes made due to reviews including weight loss is well communicated to the kitchen manager. The kitchen staff have a resident likes and dislikes list, diet plans and dietary requirements that ensure all resident needs and consumer groups are catered for. A project initiative has commenced with the Ranfurly management and Medirest kitchen manager/chef to continually improve the menu and choice offered. There is daily tastings of foods and regular
resident feedback due to the outcome of the annual resident survey. The General Manager reports there has been an increase in resident food satisfaction. The five rest home and three hospital residents confirm they are satisfied with the meals and choices offered. Internal audits are conducted. Meals are served in the rest home dining area. The hospital meals are delivered by trolley to the hospital dining area on trays with heat lids. The meals are delivered to the Bob Reed dementia care unit in the bain marie and served by the HCA’s on duty. Additional food supply such as biscuits, sandwiches, nutritious snacks for after hours is delivered at 5pm daily to the dementia unit.

The kitchen is well equipped with two combiovens to cook the 112 meals daily. The area is spacious with a good work flow and a separate side for the dishwashing. The fridge, freezer, hot and cold foods and dishwasher temperatures are monitored daily. All perishable foods in the fridge is date labelled. The pantry is clean and tidy with all dry goods labelled, sealed and stored off the pantry floor. Stock is rotated on delivery of the weekly food supplies. Chemicals are supplied by Ecolab and stored safely in the locked chemical room. Safety data sheets and wall charts for product use is provided by Ecolab. A cleaning kitchen schedule is in place. Staff on duty are observed wearing hats, gloves, cloth aprons and plastic aprons for dishwashing. The kitchen area is locked after hours.

E3.3f, there is evidence that there is additional nutritious snacks available over 24 hours
D19.2 staff have been trained in safe food handling.

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.

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Corrective Action Required:

Timeframe:

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

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Corrective Action Required:
### Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

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**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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### 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 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
- Mal
- V
- CQ
- SQ
- STQ
- Ma
- L

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

**Attainment:** PA Low

There are policies and procedures for the management and storage of chemicals. The maintenance person has completed stage 1, 2 and 3 of the Health and Safety Representative training. The chemicals are delivered to a locked chemical store room and then distributed to the kitchen, laundry and cleaning areas. An oasis system is used for the re-filling of chemical bottles. All chemical bottles are labelled correctly with manufacturers labels. A cleaning trolley was noted to be left unattended in the dementia care unit. Personal cares trolleys with chemical bottles are observed as being left unattended in the corridors (Hospital) several times throughout the two day audit. There is a current hazard register. A Chemicals spills kit readily accessible. Ecolab are the supplier for chemicals and provide product wall charts, safety data sheets, quality control...
checks and education. The doors to the staff only designated areas are lockable. There are policies and procedures in place for the management of waste and hazardous substances. Waste management bins are used for general waste and recycling. Bins are collected daily. RN's interviewed are knowledgeable in the disposal of clinical waste including infectious material into the Yellow bags, sharps into approved containers and used cytotoxic equipment into the purple approved containers. Protective clothing is supplied and readily available.

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.

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<th>Audit Evidence</th>
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<th>Risk level for PA/UA: Moderate</th>
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<tr>
<td>The chemicals are delivered to a locked chemical store room and then distributed to the kitchen, laundry and cleaning areas. The doors to the staff only designated areas are lockable.</td>
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Finding Statement
A cleaning trolley was noted to be left unattended in the dementia care unit. Personal cares trolleys with chemical bottles are observed as being left unattended in the corridors (Hospital) several times throughout the two day audit.

Corrective Action Required:
Ensure cleaning and personal cares trolleys are not left unattended at all times.

Timeframe: immediately - 1 month

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.

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<th>Audit Evidence</th>
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<th>Risk level for PA/UA:</th>
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Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.2 Facility Specifications
Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.
How is achievement of this standard met or not met? 

**Attainment: FA**

Ranfurly care building is one of the original hospital buildings and is protected under the Historic Places Trust. The Bob Reed dementia care unit is in a separate building on the same site. The buildings have a current warrant of fitness that expires 27/8/2013. Evacuation scheme approval letter is dated 14/10/2003. National Fire Protection carries out building service checks.

The hospital area is divided into the Wing (single rooms) and the Ward (four bedded rooms) which resemble the older style hospital wards. The rest home area has single rooms. There are communal toilets, showers and bathroom. Each hospital wing and ward has its own nurses’ station as does the rest home wing. The hospital area has a GP room and small resident waiting room. The physiotherapist works out of a large physiotherapy room set up with the required equipment and available for residents to attend under supervision. The lounges are large and spacious and there are several seating areas for residents including the recreational "drop in" centre and library. A large activity resource room offers an area for smaller activity groups for crafts or painting. There is a barbers room. The corridors are wide with handrails appropriately placed. The bedrooms and service areas are linoleum or vinyl flooring which is kept clean and polished. The Bob Reed unit is a 24 bed building with secure access at the main door and 24 hour video surveillance. The bedrooms are single with built in furniture. There are several bedrooms being painted and upgraded which are cordoned off. One wing of bedrooms have been upgraded. Bathrooms are communal and signage is clear. There is an open plan nurses’ station, dining, servery and lounge area. A separate lounge at the end of a wing looks out on garden and lawn. There is a safe outdoor walking area on both sides of the building. Small concrete ramps are in place between opening doors and that footpaths to ensure safe outdoor access. Outdoor seating and shade is available. There is a designated smoking area for residents. There are plans to continue improving the external grounds for the residents.

The maintenance person coordinates the day to day maintenance and checks the requisition book for requests. There are preferred contractors and quotes are obtained and forwarded to the general manager for large maintenance work. There is planned maintenance of equipment and annual electrical checks annually in September each year. The maintenance person provides a maintenance report at the Quality meetings. Environmental audits of each area is carried out three monthly. The main dining room has been painted in the rest home and a number of overdue repairs and maintenance have been completed. The maintenance of the gardens and grounds are done by a contractor two days a week. There is safe access to a gazebo and outdoor areas by ramp and handrails are in place.

E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities.

ARC D15.3; The following equipment is available, wheelchairs, high rise chairs, mobile recliners, lifting and standing hoists (serviced March-13), electric beds, ultra-low beds, weighing scales, roho cushions and air alternating mattresses, transferring belts and mobility aids.

E3.3e; There are quiet, low stimulus areas that provide privacy when required.

E3.4.c; There is a safe and secure outside area that is easy to access

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<tr>
<th>Criterion 1.4.2.1</th>
<th>All buildings, plant, and equipment comply with legislation.</th>
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<td><strong>Audit Evidence</strong></td>
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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; D15.3a; D15.3b; D15.3c; D15.3d; D15.3f; D15.3g; D15.3i; D20.2; D20.3; D20.4
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**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.

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

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**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 □ Mal □ V □ CQ □ SQ □ STQ □ Ma □ L □

How is achievement of this standard met or not met?  
Attainment: FA

The bathrooms in the hospital and rest home wing are in need of an upgrade and there is a project plan in place. There are adequate communal toilets and shower facilities. The communal toilets and shower areas in the Bob Reed unit are tidy and clean.

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.

Audit Evidence  
Attainment: FA  
Risk level for PA/UA:

Finding Statement

Corrective Action Required:

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 □ Mal □ V □ CQ □ SQ □ STQ □ Ma □ L □

How is achievement of this standard met or not met?  
Attainment: FA

The hospital area is divided into the Wing (single rooms) and the Ward (shared rooms) Privacy curtains are in place in shared rooms. Rest home bedrooms are all single. Bedroom doors are labelled with the resident name and rank and service. The hospital wing has electric beds and all the swing beds now have electric beds. Other beds are Hi-Lo beds. The dementia unit has standard beds with three electric beds for residents who require them. Bedroom doors are named. Residents/families are encouraged to personalise the bedrooms. There is adequate space to safely manoeuvre transferring equipment around the beds and for residents to freely mobilise in their rooms with mobility aids.
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 maneuver with the assistance of their aid within their personal space/bed area.

Audit Evidence

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 □  Mal □  V □  CQ □  SQ □  STQ □  Ma □  L □

How is achievement of this standard met or not met?  Attainment: FA

There are communal lounges and dining areas in all units. There are smaller areas and seating to allow for individual and group activities. There is a recreational lounge and "drop in" centre smaller, TV lounge for the men "Man Cave", large RH dining area. The long sunny and light conservatory areas accessed through the shared bedrooms is used as the hospital dining area.

The Bob Reed dementia care unit has an open plan servery, dining and lounge area. There is second lounge with appropriately placed seating and internal and external areas that allow maximum freedom of movement within a safe area.

D15.3d: Seating and space is arranged to allow both individual and group activities to occur.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander

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

Finding Statement
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 ☑  Mal ☐  V ☑  CQ ☑  SQ ☑  STQ ☑  Ma ☑  L ☐

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

Attainment: FA

The laundry and cleaning service is contracted to Medirest (Compass). The domestic supervisor oversees the service, laundry and cleaning staff, the roster, cleaning schedules, education of staff and quality assurance. The laundry operates daily from 6am to 3pm. Dirty laundry is delivered by bins to the external laundry door from the dementia unit using designated transport and trailer. Internal areas deliver dirty laundry in coloured top bins. Ecolab provide the chemical for the laundry and cleaning service and conducts monthly quality control checks on the effectiveness of machinery and chemicals used. Personal protective wear for laundry staff include household gloves, vinyl gloves, plastic aprons and face shields. Chemicals are stored in a locked chemical room. Safety data sheets are readily accessible. The service has the equipment to cope with the volume of laundry and personal clothing. There is a separate linen folding and storage room. Linen trolleys are delivered to each unit in the mornings. Covered linen trolleys in units sighted. There is adequate linen supplies in the linen room. Cleaners observed on duty are wearing appropriate protective wear for cleaning duties. The trolleys have the required cleaning equipment and chemical bottles are labelled correctly. The trolleys are not lockable. The cleaning trolley in the dementia unit is observed to be unattended. (link 1.4.1.1).

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

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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.

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<th>Audit Evidence</th>
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**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  Cl  Mal  V  CQ  SQ  STQ  Ma  L

How is achievement of this standard met or not met?  

**Attainment: FA**

Appropriate training, information, and equipment for responding to emergencies is provided. Fire training is completed at orientation and fire evacuations are held six monthly. A fire evacuation was last held on 27-April-13.

D19.6 There are emergency management plans in place to ensure health, civil defence and other emergencies are included. There is an approved evacuation plan dated 14-Oct-03. The facility is well prepared for civil emergencies and has civil defence kits (readily accessible in each of the three areas) and emergency lighting. A store of emergency tank water is available. There is gas bottles/burners for alternative heating and cooking and emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are also available. Hoists have battery backup and there are batteries that can be used to operate electric beds/hoists in the event of a power failure. Oxygen cylinders enable residents to switch from concentrators to cylinders in the event of a power failure and there is a list of names and contact details of staff so that they can easily be contacted in an emergency. At least three days stock of other products such as incontinence products and PPE are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas staff carry pagers to alert of residents requesting assistance. A new call bell system has been installed in Bob Reed dementia unit. During the tour of the facility and during interviews, residents were observed to have easy access to the call bells. Visitors sign in/out book at reception and the facility is secured at night. The front door to the rest home/hospital is locked by staff at 18.00 hours and opens at 06.45 hours. Visitors use the call button for staff assistance. Eight residents interviewed (three hospital, five rest home) stated their bells were answered in a timely manner. There are staff on duty each shift who hold a current first aid certificate.
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.

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

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

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

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

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**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 □  Mal □  V □  CQ □  SQ □  STQ □  Ma □  L □

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

Attainment: FA
All rest home bedrooms and the hospital single rooms have an external window with adequate natural light. The hospital shared rooms have external windows in the conservatory area which allows adequate natural light into the bedroom. There have been 17 beds decommissioned. There is radiator central heating throughout the facility. Scope heaters are placed where required to maintain the warm and comfortable environment. The five rest home residents and three hospital residents interviewed state their rooms are warm and comfortable.

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

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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.

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Corrective Action Required:

Timeframe:

2. HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS

OUTCOME 2.1  RESTRAINT MINIMISATION
STANDARD 2.1.1  Restraint minimisation
Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a  ARHSS D16.6
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
Ranfurly Care Ltd has a comprehensive restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers.
The policy includes that enablers are voluntary and the least restrictive option. Forms include a restraint and enabler register, a restraint assessment form, a restraint consent form and restraint monitoring form.
Strategies are in place to minimise the use of restraint including, lipped mattress, sensor mats, hi-low beds, mobility aids and regular observation of residents.
There is one resident with an enabler (bedrail) in use and five restraints (bedrails). One enabler file was reviewed and included consent and assessment.
Two restraint files were reviewed and both contained assessments, consents and evaluation of the need for continued use of restraint. Restraint monitoring forms were evidenced completed by staff.
E4.4a: the care plans reviewed in Bob Reed dementia unit focused on promotion of quality of life and minimised the need for restrictive practices through the management of challenging behaviour.

Criterion 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.

Audit Evidence  Attainment: FA  Risk level for PA/UA:
Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 2.2  SAFE RESTRAINT PRACTICE
Consumers receive services in a safe manner.
STANDARD 2.2.1  Restraint approval and processes

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

ARC D5.4n ARHSS D5.4n, D16.6

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 restraint coordinator is the care manager who is a registered nurse. She has signed a restraint coordinator position description sighted and signed and dated 24-Sept-12. The care manager is currently orientating the quality coordinator/RN to take over the role of restraint co-ordinator in August 2013.

The restraint co-ordinator and quality coordinator have both attended education of restraint minimisation and prevention. Assessment and approval processes for a restraint intervention includes input from the restraint coordinator, RN, resident/or representative and medical practitioner.

Criterion 2.2.1.1  The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

Audit Evidence  
Attainment: FA  
Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.2  Assessment

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

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 completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint coordinator, registered nurse, the resident and/or their representative and a medical practitioner are involved in the
assessment and consent process. Consent for the use of restraint is completed with evidence of family involvement. A 'consent for restraint' form is used to document approval. These were sighted in the two files reviewed where restraint is being used.

Criterion 2.2.2.1 In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

(a) Any risks related to the use of restraint;
(b) Any underlying causes for the relevant behaviour or condition if known;
(c) Existing advance directives the consumer may have made;
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
(f) Maintaining culturally safe practice;
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
(h) Possible alternative intervention/strategies.

Audit Evidence

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 2.2.3 Safe Restraint Use
Services use restraint safely
ARC D5.4n ARHSS D5.4n, D16.6
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

Risk level for PA/UA:
The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified. An assessment form/process is completed for all restraints. The two files reviewed had a completed assessment form and care plans that reflect risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the two files reviewed. The two files reviewed have a consent form detailing the reason for restraint and the restraint to be used. In resident files reviewed, monitoring forms had been completed. A six monthly evaluation of restraint is completed that reviews the restraint episode. The continued need for restraint is also discussed and evaluated at RN meetings which are held 4-6 weekly. The service has a restraint/enabler register that is updated each month.

Criterion 2.2.3.2
Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

(a) Only as a last resort to maintain the safety of consumers, service providers or others;
(b) Following appropriate planning and preparation;
(c) By the most appropriate health professional;
(d) When the environment is appropriate and safe for successful initiation;
(e) When adequate resources are assembled to ensure safe initiation.

Audit Evidence

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 2.2.3.4
Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

(a) Details of the reasons for initiating the restraint, including the desired outcome;
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
(c) Details of any advocacy/support offered, provided or facilitated;
(d) The outcome of the restraint;
(e) Any injury to any person as a result of the use of restraint;
(f) Observations and monitoring of the consumer during the restraint;

(g) Comments resulting from the evaluation of the restraint.

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**Finding Statement**

Corrective Action Required:

Timeframe:

**Criterion 2.2.3.5** A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

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**Finding Statement**

Corrective Action Required:

Timeframe:

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

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 has documented evaluations of restraint every month. The restraint process considers the items listed in # 2.4.1. In the two restraint files reviewed, evaluations had been completed with the resident, family, restraint co-ordinator and medical practitioner.

Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator. A restraint evaluation is completed for each resident using restraint. Evaluation of restraint was evidenced completed six monthly. The evaluations had been completed in the two files reviewed with the resident, family, restraint co-ordinator and medical practitioner.

Criterion 2.2.4.1 Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

(a) Future options to avoid the use of restraint;
(b) Whether the consumer's service delivery plan (or crisis plan) was followed;
(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
(d) Whether the desired outcome was achieved;
(e) Whether the restraint was the least restrictive option to achieve the desired outcome;
(f) The duration of the restraint episode and whether this was for the least amount of time required;
(g) The impact the restraint had on the consumer;
(h) Whether appropriate advocacy/support was provided or facilitated;
(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
(j) Whether the service's policies and procedures were followed;
(k) Any suggested changes or additions required to the restraint education for service providers.

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Criterion 2.2.4.2 Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.
**STANDARD 2.2.5  Restraint Monitoring and Quality Review**

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5.4n   ARHSS D5.4n, D16.6

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?**

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<td>(a)</td>
<td>The extent of restraint use and any trends;</td>
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<td>(b)</td>
<td>The organisation's progress in reducing restraint;</td>
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<td>(c)</td>
<td>Adverse outcomes;</td>
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<td>(d)</td>
<td>Service provider compliance with policies and procedures;</td>
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<td>(e)</td>
<td>Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</td>
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<td>(f)</td>
<td>If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</td>
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<td>(g)</td>
<td>Whether changes to policy, procedures, or guidelines are required; and</td>
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<td>(h)</td>
<td>Whether there are additional education or training needs or changes required to existing education.</td>
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**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

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<td>The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service.</td>
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<td>The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control coordinator and clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system. The infection control committee includes a cross section of staff all areas of the service.</td>
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<td>The infection control co-ordinator (Care Manager) and GM are responsible for the development of the infection control programme and its review. The programme is reviewed annually. The facility uses the &quot;Bug Control&quot; manual and Ranfurly Care Infection control policies make reference to the relevant areas in the Bug Control manual. The facility has access to professional advice as it has developed close links with the G.P's, local laboratory the infection control and public health departments. The facility is also a member of Bug Control.</td>
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<td>There are two monthly infection control meetings. The meetings also include a discussion and reporting of infection control matters and the consequent review of the programme. Information from these meetings is passed onto the registered nurse and staff meetings. Minutes are available for staff.</td>
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<td>The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Communal toilets/bathrooms have hand hygiene notices in large print. There is a staff health policy.</td>
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<td>An outbreak of diarrhoea in the rest home area in June 2013 which included 11 residents and four staff was well managed. The service completed a short term care plan for each resident affected, daily clinical observations, an outbreak meeting was held and an Infection Control Special Report Form was completed. Public Health and ADHB were informed of the outbreak. Communication with family/whanau is documented.</td>
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In July 2013 the GM was advised that a kitchen staff member has been admitted to hospital. Further follow up by GM occurred and found that the staff member was diagnosed with pneumococcal meningitis. Public Health and ADHB were contacted. Staff were provided with information/hand outs on pneumococcal meningitis and informed that Public health had advised that there was no potential harm to residents or staff. Staff were reminded at handover sessions re hand hygiene etiquette. There have been no other cases identified.

### 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.

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**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.

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**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.

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STANDARD 3.2  Implementing the infection control programme

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

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 infection control committee is made up of a cross section of staff from all areas of the service including: (but not limited to) the GM, QM, registered nurses and other staff. The facility also has access to an infection control nurse, public health, local laboratory, G.P's and expertise from Bug Control organisation.

Criterion 3.2.1  The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Audit Evidence  Attainment: FA  Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.3  Policies and procedures
Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a  ARHSS D5.4e, D19.2a

Evaluation methods used: D  S I  STI  MI  Cl  Mal  V  CQ  SQ  STQ  Ma  L

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

**Attainment:** FA

**D 19.2a:** The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff.

There is also a scope of the infection control programme, standards for infection control, infection control prep, responsibilities and job descriptions, waste disposal, and notification of diseases.

Infection control procedures developed and contained in the kitchen, laundry and the housekeeping manuals incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual.

External expertise can be accessed as required, to assist in the development of policies and procedures. Policy development involves the infection control coordinator (CM), the infection control committee, GM, and external DHB input.

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**Criterion 3.3.1** There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

**Audit Evidence**

**Attainment:** FA

**Risk level for PA/UA:**

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**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

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**STANDARD 3.4** Education

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e  ARHSS D5.4e

Evaluation methods used: D  S I  STI  MI  Cl  Mal  V  CQ  SQ  STQ  Ma  L
The infection control coordinator is responsible along with the education coordinator for coordinating/providing education and training to staff. The IC coordinator has attended an IC seminar. There are internal and external seminars available for training as well as access to the infection control nurse, microbiologist, pharmacist, IPA, Bug Control and local laboratory for additional education for both the co-ordinator and the staff. The orientation package includes specific training around hand hygiene and standard precautions. Training on infection control was held in January, April, May and June 2013 with a total of 30 staff attending.

Resident education is expected to occur as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs. There is evidence of consumer and visitor education around influenza and gastro bugs.

**Criterion 3.4.1**  Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

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**Criterion 3.4.5**  Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

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STANDARD 3.5   Surveillance

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

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 surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and infection control meetings. The meetings include the monthly infection control report. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme.

Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP’s that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.

Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken. The infection rate has reduced from 5.28 % per month in 2010 to 4.40 % in the rest home in 2012, 6.34% in the dementia unit in 2010 to 3.07% in 2012 and in the hospital 6.5% to 4.3% in 2012.

Criterion 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.

Audit Evidence

Attainment: FA

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 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.
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