Ranfurly Manor Limited - Ranfurly Residential Care Centre

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Ranfurly Manor Limited
Premises audited:	Ranfurly Residential Care Centre
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 23 September 2015 End date: 25 September 2015

Proposed changes to current services (if any): Addition of 'hospital services – medical' to the services being provided at Ranfurly Residential Care Centre

Total beds occupied across all premises included in the audit on the first day of the audit: 127

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Ranfurly Residential Care Centre is a purpose built facility with 74 hospital rooms and 43 one bedroom and 10 two bedroom apartments. The apartments are purchased under occupation right agreement and are all certified for either rest home or hospital level care (referred to as dual use). There is a secure dementia unit within the facility where support for 20 people who require this level of care is provided. (There are a further five beds within the unit not yet approved for use.) Ranfurly Residential Care Centre is privately owned and operated.

This certification audit was conducted against the Health and Disability Services Standards and the provider's contracts with the district health board. These contracts include the provision of short term health recovery and palliative care services. To support this the addition of hospital services (medical) to the provider's scope of service is being added.

One area for improvement is noted in relation to the assessment of needs using the interRAI assessment tool. Three areas of excellence are identified in relation to quality improvement systems, medication management and the model of care used in Ranfurly's dementia unit.

Consumer rights

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

Care provided to residents is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected.

Residents who identify as Maori are supported by the provision of appropriate policies, procedures and community connections.

Residents interviewed feel safe, there is no sign of harassment or discrimination, staff communicated effectively and residents are kept up to date with information. Residents, or their enduring power of attorney, sign a consent form on entry to the service with separate consents obtained for specific events.

The service informs residents and their families of how to access the Nationwide Health and Disability Advocacy Service and encourages residents to maintain connections with family, friends and their community and to access as many community opportunities as possible.

Residents and family/whanau are provided with information on raising concerns and making complaints on entry and information is in central places in the facility. Complaints are managed by the general manager respectfully and in a timely way. An up to date register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Ranfurly Residential Care Centre is managed by an experienced general manager and facility manager. There are teams for each functional area and each is led by an experienced staff member with designated responsibilities for supervision of their team. The general manager has resigned and her replacement has been appointed. This person brings a range of relevant experience in the aged care sector.

A well-developed quality and risk management system is implemented with related information utilised to make improvements. Team leaders provide verbal and written reports each month and the quality and risk management plan is monitored regularly. There is an internal audit calendar which reviews all areas of service delivery. Quality initiatives are incorporated into the quality plan, and the organisation's system for development and evaluation of these initiatives, is a particular strength and is rated as 'continuous improvement'.

Staff members report feeling well supported by the management team. There is a sound human resources management system which includes recruitment and appointment of staff members to meet residents' needs. A comprehensive training programme maintains a high level of competence for all staff. Effective allocation of staffing occurs across the facility to provide safe support to residents.

Residents' information is accurately recorded, and all information is securely stored and not accessible to the public. Service providers use up to date and relevant residents' records.

Continuum of service delivery

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

The organisation works closely with the Needs Assessment Coordination Service to ensure access to the service is efficient and relevant information is provided, whenever there is a vacancy.

Residents' needs are assessed on admission by the multidisciplinary team; however, the requirement to use the interRAI assessment tool is not being met. All residents' files sighted provided evidence that needs, goals and outcomes are identified and reviewed on a regular basis. An initiative implemented in the dementia unit to plan residents' individualised care is recognised as an area of continuous improvement. Residents' and families interviewed reported being well informed and involved, and that the care provided is of a high standard.

An activities programme exists that includes a wide range of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice. Practices sighted are consistent with these documents. A new medication management initiative to minimise the risks associated with hand written medication charts has been implemented and this is identified as an area of continuous improvement.

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. Residents have a role in menu choice and interviews with residents verified satisfaction with meals.

Safe and appropriate environment

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

The facility is purpose built and has been open for almost two years. It is well maintained and is in good condition. All areas of the facility, and especially residents' rooms and communal areas, are kept clean, well ventilated and at a comfortable temperature. The building has been constructed with a variety of different internal and external spaces for residents to use, including an activities room, a media room and several large lounge/dining areas.

There is a building wide call bell system in place which is answered promptly. The system has an electronic monitoring facility which enables review of any concerns raised in relation to response times.

There are effective systems in place for the management of waste and hazardous substances, cleaning and laundry, which is all done on site, and monitoring of these by the team leaders and the quality coordinator.

Emergency management systems and procedures are in place and there are effective security systems in place for daily security. There is a back-up generator on site and relevant supplies in the event of a civil defence emergency.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Since the last on site audit the restraint minimisation and safe practice policy and procedures have been reviewed by the quality and restraint coordinator and general manager. The newly updated system meets the requirements of the standard and is now more explicitly focused on minimisation.

Review of residents using both restraints and enablers demonstrates that the system is in place and documentation for assessment, consent, review, evaluation of restraints when in use, and monitoring of overall restraint use is occurring as planned. The quality review of restraint use is providing a detailed analysis of the use of both restraints and enablers and changes in residents' needs over time.

Feedback from family/whanau members confirms that the restraint and enabler processes are meeting needs for safety and independence. Staff members report that the training they receive provides them with appropriate information to be able to support residents and family/whanau when restraint use is required and to explore alternatives when possible.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The service provides an environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined with the infection control nurse reporting directly to the facility manager who reports to the general manager.

There is an infection prevention and control programme for which external advice and support was sought; this is reviewed annually. An infection control nurse is responsible for this programme, including education and surveillance.

Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections has been collated and analysed. Surveillance results are benchmarked internally. The results of surveillance are reported through all levels of the organisation, including governance.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	49	1	0	0	0	0
Criteria	3	97	1	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Interviews with residents and family members of residents receiving health recovery, rest home, hospital or specialised dementia care services verified services provided complied with consumer rights legislation. Policy documents, the staff orientation programme, in-service training records, education programmes, interviews with staff and satisfaction surveys verified staff knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). Clinical staff were observed to explain procedures, seek verbal acknowledgement for a procedure to proceed, protect residents' privacy, and address residents by their preferred name.
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.	FA	The informed consent policy describes all procedures to ensure the resident's rights to be informed of all procedures undertaken. Documentation, observation and interviews evidence information is provided to make informed choices. Informed consent is understood and is included in the admission process. The resident, and where desired family/whanau, are informed of changes in the resident's condition and care needs, including medication changes. Residents' choices and decisions, including advances

		directives, are recorded and acted on where valid.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	The service recognises and facilitates the rights of residents and their family/whanau to advocacy/support by persons of their choice. The facility has open visiting hours. Residents are free to access community services of their choice and the service utilises appropriate community resources, both internally and externally. Residents and their families are aware of their right to have support persons.
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.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family/whanau and the community by attending a variety of organised outings, visits, activities, and entertainment at various locations, with the support of the service. The service acknowledged values and encouraged the involvement of families/whanau in the provision of care, and the activities programme actively supports community involvement.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Information about the complaints process is provided to new residents on entry. Staff receive training at orientation and updates in the annual training programme. The policy is consistent with Right 10 of the Code of Health and Disability Services Consumers' Rights. The form to use to make a complaint is easily available within the facility. The general manager handles all complaints and maintains the complaints register. At the time of the audit the register was current and up to date. Staff members interviewed were all familiar with the process of handling a complaint and described the ways they would support a resident and/or family/whanau member to raise concerns or report a complaint.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Interviews, observations and documentation verified residents are informed of their rights. Information on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and the Nationwide Health and Disability Advocacy Service is displayed and accessible to residents. Discussion, clarification and explanation on the Code and the Advocacy Service occurs at admission. Legal advice is able to be sought on the admission agreement or any aspect of the service. Information is provided on the facility's range of costs and services.

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.	FA	Policy identifies that procedures are in place to ensure residents are kept free from discrimination, harassment, abuse and neglect, including the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse. Residents receive services which treat them with respect and has regard for their dignity, privacy, sexuality, spirituality and independence. Staff demonstrated policy awareness and responsiveness to residents' needs.
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.	FA	Documentation is in place to guide staff practice to ensure residents' needs are met in a manner that respects and acknowledges their individual cultural, values and beliefs. Policy states that this is to be identified upon entry as part of a resident's care planning process. The organisation had a documented Maori Health Plan which identified their priorities related to culturally safe services. The service recognises the relationship between iwi and the Crown and the principles of the Treaty of Waitangi (Partnership, Participation and Protection). Whanau relationships and involvement in care are recognised. Evidence verified ongoing liaison with local iwi, to facilitate the facility's ability to meet the needs of Maori residents. There are residents receiving services who identified as Maori at the time of audit. Staff receive education in relation to cultural safety and the Treaty of Waitangi.
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.	FA	Policy identifies that residents receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values and beliefs. Evidence verified residents' received and are consulted on culturally safe services which recognised and respected their ethnic, cultural and spiritual values and beliefs. A training programme, aimed at personalising end of life care was piloted at Ranfurly Residential Care Centre (RRCC) in response to a community audit identifying the cultural needs of clients receiving palliative care in the mid central region, were not being met. The programmes aim is to promote staff understanding of cultural goals and their importance in individualised care and increase staff competence and confidence in assessing cultural goals and developing appropriate responses. As a result of its success this training is now being offered regularly at RRCC and is now available for other facilities to implement.

		Another finding of the communities audit identified a need for 'palliative care suites' to be available in residential care facilities to encompass the entirety of residents' cultural needs. This service has been instigated at RRCC. Interviews verified all resident and family needs were being met for this group of residents.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Policy indicates that residents are to be free from all forms of discrimination, coercion, harassment and exploitations. Orientation/induction processes inform staff on the Code. The company's code of conduct, policies and procedures provide clear guidelines on professional boundaries and conduct, and inform staff about working within their professional boundaries. Interviews verified staff understanding. Residents felt safe and received a high standard of support and assistance and reported there was no sign of harassment or discrimination.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages good practice. Policies sighted were current, relevant and referenced to related sources, legislation and the Health and Disability Services Standard requirements. Policies reflected current evidence based best practices, which are monitored and evaluated at organisational and facility level. Evidence verified a range of opportunities is provided to enable staff to provide services of a high standard. The general practitioners (GPs) interviewed confirmed the service sought prompt and appropriate medical intervention when required and responded appropriately to medical requests.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Staff are guided by policies which include clear information about open disclosure and provision of interpreter services when required. Examples of how to practice open disclosure are included in the incident report training. During interviews with a wide range of staff members they discussed the importance of developing and maintaining good communication with families/whanau, particularly when incidents have occurred. Family members interviewed confirmed that they receive information when appropriate and there is good communication. This is also confirmed in results of satisfaction surveys in 2015.
Standard 1.2.1: Governance The governing body of the organisation	FA	Ranfurly Residential Care Centre's (RRCC's) purpose, values, scope and goals are clearly defined and are included in a range of strategic documents as well as position descriptions. Strategic documents are reviewed annually by the general manager and management team

ensures services are planned, coordinated, and appropriate to the needs of consumers.		(facility manager, quality coordinator and general manager). The general manager is in regular contact with the owner and director. The current management team are experienced registered nurses who have a range of experience across the health sector and particularly in aged care. The general manager has recently resigned and her replacement has worked in the sector in a range of relevant positions.
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.	FA	There are appropriate arrangements for the temporary absence of a member of the management team. The facility manager recently had eight weeks annual leave. During this time formal arrangements were made for her role to be undertaken by other staff members. This included her clinical responsibilities being undertaken by an experienced registered nurse and the general manager performing her management responsibilities. Staff members interviewed stated that this was communicated to them and worked well.
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.	FA	There is a quality and risk management system at RRCC which has been significantly redeveloped in the last 18 months and implemented within the facility. The current annual quality plan clearly outlines the requirements of these standards and contracts held by the provider. The systems for document control and management are effective and ensure that policies and procedures are clear and provide practical resources for staff members to follow. The quality coordinator and general manager review and update all documents, incorporating current research and best practice guideline and references when appropriate. Other staff members are involved when their area of expertise is relevant to the topic. All documents reviewed were current at the time of the audit. Accident and incident monitoring data (AIMs) is collated by the quality coordinator and graphed on a monthly basis. Rates are compared to the benchmarks in the quality plan and discussed in each team at regular meetings. Staff members confirm this at interview and were able to discuss issues and trends at these meetings. There is a comprehensive programme of internal audits managed by the quality coordinator and implemented by both quality coordinator and team leaders. These monitor key aspects of service delivery and the results are reported to staff. Corrective action is taken in response to individual events and recorded on individual reporting forms. Where trends or systemic issues are identified RRCC develops quality initiatives and projects to improve areas. The quality plan requires that a minimum of five quality initiatives be developed annually and the facility has already developed more than this number. (Two of these quality initiatives are identified as areas of strength under standards 1.3.6 and 1.3.12). Staff

		members interviewed stated that they were able to make changes and improvements at any time they were needed. The management team maintains a well-documented risk management plan. This identifies business risks and how they are being managed. The plan is formally reviewed each year with risk management activities occurring throughout the year. Risk management activities were observed in records reviewed and confirmed through interviews with staff members across the facility.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Essential notification is included in policy documentation and known and understood by management team members, who are responsible for this function. All adverse events are reported on accident and incident monitoring (AIM forms). These are reviewed by team leaders to ensure immediate follow-up is appropriate and then all AIMs are recorded on a database. This allows for collation of the data by the quality coordinator and then comparison with the benchmarked rate for each type of event. Staff members interviewed reported that they receive information at their regular team meetings and at the whole facility staff meetings. The graphs are provided at these meetings and minutes and graphs are available in the staff meeting for reference afterwards. There is evidence of collated AIMs data being used to manage risk and improve service delivery.
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.	FA	The human resources management policies and procedures are consistent with good employment practices. All requirements of this standard are incorporated within these policies and are implemented by the administration manager with oversight by the management team depending on the role being filled. All health and allied health professionals either employed by or who contract to the facility have their practising certificate or professional registration validated at commencement of their work and monitored from then onwards. Records of these were reviewed during the audit and are up to date for all qualified nurses at the facility and contracted health workers. Personnel files were sampled and included recently recruited and longer term staff members. This confirmed that recently appointed staff members have had a complete recruitment, including interviews, reference and police checks, and an orientation appropriate to their position in the organisation. Longer serving staff have had an annual performance appraisal and ongoing training and competency assessments appropriate to their positions. All staff members are provided with an annual training programme which incorporates the core

		requirements of these standards and contracts held by the organisation. The complete orientation and ongoing training programme provides staff members with appropriate training and competency assessment to enable them to undertake their roles safely. Additional training is accessed externally when required. Staff education is overseen by the caregiver coordinator for the caregivers in the main facility, the dementia team leader in the dementia unit. The kitchen, cleaning and laundry team leaders monitor the training of their teams with support from the quality coordinator. The quality coordinator, administration manager and a senior registered nurse have oversight of the qualified nursing teams' training. The education programme involves generic education for all staff including an annual training calendar. Nursing staff members are supported to maintain their practising certificates through the completion of relevant clinical study. All caregivers are required to complete the Careerforce qualification the facility has developed for itself which incorporates level 2, 3 and 4 unit standards. (The level 4 unit standards are those which make up the dementia qualification.) All the unit standards are drawn from the two core competencies certificates in support of the older person. The two cooks hold the food hygiene unit standards and both have completed a range of other training in hospitality and food services. All kitchen staff maintain their knowledge in the basics of food hygiene. Housekeeping staff members complete training in the safe use of chemicals and cleaning solutions. Hospice New Zealand's palliative care programme has been included in the annual training programme over the past two years. At the time of this audit a range of nursing and care giving staff have either completed or are underway with this programme. Other staff members from the wider facility are completing this programme as well (eg, housekeeping team leaders and staff members) so that the knowledge and understanding of how to support people at the end of life is throughout the staff team. Staff members report gaining increased skills and knowledge from the Hospice NZ programme. All staff members interviewed stated that the training they received prepared them well for their roles and was timely and appropriate. Caregivers in particular valued the access to a formal qualification. Records of training and education completion are maintained and a sample was reviewed. The caregivers' coordinator and administration manager maintain all of the formal training attendance records. Completion is regularly monitored to ensure training is completed within specified timeframes. While attendance by RN staff is incorporated into the annual training plan, staff turnover has left the organisation with three interRAI trained nursing team members. Another two staff members are registered for the next available training course to run in the region. (See standard 1.3.4 and area for improvement identified in relation to interRAI assessments.)

Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented policy and procedure for safe staffing at Ranfurly Residential Care Centre. It allows for changing levels of need in the different areas (that is, hospital wings, apartments) and reflects numbers of staff needed in each team. Rosters were reviewed with the facility manager and reflected staffing levels which met the needs of residents. At interviews with staff members they reported that staffing levels are safe. Resident and family/whanau surveys over the past 18 months indicated that there is a high degree of satisfaction with the staffing levels and staff members at Ranfurly.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	There was no personal or private resident information on public display during the audit. The resident's name and date of birth and national health index (NHI) number are used as the unique identifier on all resident's information sighted. Clinical notes are current and integrated with GP and auxiliary staff notes. The files are kept secure in each wing and only accessible to authorised people. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical examination by the GP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity, religion, national health index number (NHI), the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers are all recorded in each resident’s record. Archived records are held on site in a secure room. These are catalogued for easy retrieval.
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.	FA	When the need for service had been identified, it is planned, coordinated and delivered in a timely and appropriate manner. Information about the service, includes full details of the services provided, its location and hours, how the service is accessed and identifies the process if a resident requires a change in the care provided. Files reviewed contained completed assessments. Signed admission agreements met contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge,	FA	Exit, discharge or transfer is managed in a planned and coordinated manner, with an escort. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the progress notes.

or transfer from services.		
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.	FA	The medication management policy is comprehensive and identifies all aspects of medicine management. A potential risk related to handwritten medication charts was identified in December 2014 and a quality initiative implemented to manage the risk. This is an area identified as one of continuous improvement. A safe system for medicine management is observed on the day of audit, using an electronic medication management system. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administers medicines are competent to perform the function they manage. Controlled drugs are stored in separate locked cupboards. Controlled drugs are checked by two nurses for accuracy in administration. The controlled drug register evidences weekly and six monthly stock checks and accurate records. The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range. A review of the electronic medication records verifies accuracy in dispensing and three monthly medication reviews by the residents' GPs. Residents' who self-administer their medicines have appropriate processes in place to ensure this is managed in a safe manner. Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified. Standing orders are not used. Any pro re nata (PRN) (as required) medication administered requires authorisation on the resident's medication chart. A PRN medication request includes indications for use.
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	FA	The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented assessment of the planned menu. A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special

delivery.		equipment, to meet resident's nutritional needs, is sighted. The nutritional needs of residents in the dementia unit are met, with a wide range of foods being available in the unit 24 hours per day. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme. A cleaning schedule is sighted as is verification of compliance. Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience.
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.	FA	An interview with the facility manager verified a process existed for informing residents, their family/whanau and their referrers if entry is declined. The reason for declining entry would be communicated to the referrer, resident and their family or advocate in a timely and compassionate format that was understood. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Negligible	On admission, residents have their needs identified through a variety of information sources that includes the Needs Assessment and Service Coordination (NASC) agency, other service providers involved with the resident, the resident, family/whanau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident's bedroom or the whanau room with the resident and/or family/whanau present if requested. Over the next three weeks, the RN undertakes a range of assessments, as clinically indicated, which are reviewed six monthly or as needs, outcomes and goals of the resident change. A requirement for the use of the interRAI assessment to inform care planning has however not been met. A medical assessment is undertaken within 24 hours of admission and reviewed as a resident's condition changes, monthly or three monthly if the GP documents the resident is stable.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and describes the required support the resident needs to meet their goals and desired outcomes. Care plans evidence service integration with progress notes, activities notes, and medical and allied health professional's notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to those concerned. Care plans are evaluated six monthly or more frequently as the resident's condition dictates. Interviews and documentation verified resident and family/whanau involvement. The dementia unit has implemented a model of care that focuses the care planning around the specific needs of each individual. The philosophy of care was developed in consultation with families of residents in the unit at that time. The effectiveness of the model for planning resident care is an area identified as one of continuous improvement.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents' needs and desired outcomes. Residents and family/whanau members expressed satisfaction with the care provided. There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents' needs. The newly developed palliative care suites initiative has involved the designation of an apartment for the use a resident who is receiving end of life care under the 'Chronic Medically Ill' funding stream. Either the resident or their family/whanau will stay in the apartment. This provides them with an opportunity to be together during the last few days of life, in a private environment with the opportunity to stay on site, shower, and have their own space with or near their loved one. Staff spoke about the palliative care suite with a great deal of pride. A representative from the local hospice was interviewed and spoke very positively about palliative care support being provided at Ranfurly. They are very pleased to recommend these services.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity	FA	The activities programme is run by two diversional therapists. Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents.

requirements are appropriate to their needs, age, culture, and the setting of the service.		The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate. The dementia unit, has a programme in place that focuses on resident involvement in all aspects of community life, this includes participation in activities in other areas of the facility where appropriate. A residents' meeting is held bimonthly. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated daily and reported in the progress notes. If any change is noted it is reported to the RN. Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change and are carried out by the RN. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan. Short term problems are included in the care plan and reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews, verified residents and family/whanau are included and informed of all changes
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.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance from the DHB. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate.
Standard 1.4.1: Management Of Waste	FA	All staff are introduced to the documented procedures for management of waste and hazardous substances at orientation and annual update training. Cleaning, laundry and care assistant staff

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.		members receive more specific training appropriate to their roles and the particular involvement they will have in waste management. Protocols and procedures are available for all staff to reference and were seen during the audit visit. Similarly adequate supplies of protective equipment and clothing were observed throughout the facility and in areas where staff will access them most frequently. Additional supplies are maintained on site. At interview with a wide range of staff members all confirm that they receive appropriate training to undertake their roles and have ready access to supplies, equipment and procedures to protect residents, visitors, other staff and themselves from harm as a result of exposure to waste, infectious or hazardous substances.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building is currently covered by a Certificate of Public Use which expires on 30 October 2015. As a new build in 2013, most of the building, plant and equipment systems are still covered by their initial warranty. At interview, the maintenance person reported that he is responsible for monitoring building maintenance, systems and equipment and will engage external contractors as required. To date needs have been minimal. Ranfurly Residential Care Centre in its new location has been purpose built with features that promote independence, safety and mobility. Surfaces are non-slip in bathrooms, kitchens, sluice rooms and other work spaces for staff. Carpets are low rolling resistance and stain and odour resistant. The facility has been designed so that every room looks out onto a garden/courtyard and, except for the RDC (Ranfurly Dementia Care unit) internal rooms have access to these external spaces. Residents interviewed comment on the environment and satisfaction surveys confirm high levels of satisfaction from residents and families/whanau.
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	FA	All hospital rooms have their own ensuite toilets (with hand basins) and apartments have an ensuite bathroom. In the four wings of the hospital, bedrooms (with ensuite toilets), there are an adequate number of shower rooms (11 in total) for the residents using them. Two of the showers are in the dementia care unit. At interview with staff they report that people rarely have to wait for a shower. In the dementia care unit resident's toilets have different coloured seats to enable independence for as long as possible. Ensuite toilets are large enough to enable up to two staff to assist a

with personal hygiene requirements.		resident should this be required. There are appropriate hand rails in all toilets. Additional toilets for visitors and staff are available in the facility and are clearly identified as such.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All bedrooms are of a generous size to accommodate a hospital style bed and mobility equipment. This provides flexibility within the facility should residents needs change. Individual residents and families/whanau have personalised rooms as they have chosen and many have become quite individualised. Observed during the audit visit are residents who use lay-z-boy type chairs in their rooms as well as other personal furniture. Additional mobility equipment can also be accommodated. Apartments are larger and can accommodate more personal items and furniture, while still allowing for equipment and safe manoeuvrability of mobility aids when this is required. Residents and family/whanau interviewed during the audit reported a high level of satisfaction with the size of bedrooms at Ranfurly and also the finishings. Apartments are appealing for people who choose this option due to the layout and presentation.
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.	FA	There are five separate dining / lounge areas and additional alcoves with seating throughout the facility. In addition there is a large activities room with a kitchenette which can be used by families/whanau for entertaining and meetings when not otherwise in use. More than half the facility is made up of individual apartments, and these residents are observed to spend time in their own lounge/living rooms even when they may choose to have their meals in one of the dining rooms and / or join in with activities. Feedback from residents and family/whanau interviewed during the onsite audit and in satisfaction surveys confirms a high level of satisfaction with the environment at Ranfurly.
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.	FA	The team leaders of cleaning and laundry services have systems for monitoring the effectiveness of their services. Frequent and regular monitoring is conducted by the team leaders with detailed records maintained. A three monthly environment audit conducted by the team leaders with the quality coordinator. The external contractor of cleaning and laundry chemicals also visits weekly and monitors the effectiveness of their products. These records are used by the team leaders and quality

		coordinator to inform their monitoring. The records of the consistent monitoring activities, and observation of the environment, confirms that cleaning and laundry services are provided to a high standard. There are occasional problems with correctly identifying laundry items, however overall the systems are in place to ensure safe and hygienic services. Satisfaction survey results from the two recent surveys (late 2014 and 2015) indicate a high level of satisfaction with laundry services from residents and family/whanau.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The orientation and ongoing training programme includes information and training for all staff in responding to emergency situations and dealing with security. All staff interviewed referred to this training and understood their responsibilities for keeping residents safe. Records were reviewed with the general manager and quality coordinator relating to emergency planning. A comprehensive and clear plan has been developed and implemented which is specific to Ranfurly at its new site. The approved evacuation plan was sighted and incorporates the now fully completed aged care facility. There are alternative energy and utility sources available in the event that main supplies fail. Ranfurly is also on the local city council's emergency response plan and a significant site which will require assistance in a civil defence emergency. All rooms (bedrooms, bathrooms, communal areas and visitors bathrooms) have emergency call bells. There are two calls – one for assistance and one for urgent assistance. This electronic system can be monitored and records of this monitoring were reviewed with the quality coordinator. These allow for close assessment of any concerns with response times or multiple use to ensure appropriate care is provided. All external doors are locked at an identified time at night by the RNs on duty and unlocked in the morning. During the night time there is a front door bell so that families can gain access.
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.	FA	The design of Ranfurly is so that every room has at least one, large, external window which can be opened to allow in fresh air. Except for the dementia care wing, bedrooms and apartments which look onto an internal courtyard have a 'ranch slider' door so that the external space can be accessed. Rooms on an outside wall have two large windows, one of which opens with a security stay. All rooms have natural light while the windows are double-glazed.

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.	FA	The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. The infection control programme, reviewed annually, establishes, maintains and monitors procedures covering infection control practices. The infection control practices are guided by the infection control manual, with assistance from the DHB infection control nurse where needed. It is the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Evidence of practice relating to these policies was sighted at audit. Reporting lines are clearly defined.
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.	FA	The infection control nurse (ICN) is responsible for implementing the infection control programme and reports directly to the facility manager. A position description is included in the infection control (IC) programme. The ICN and observation verified there are enough human, physical and information resources to implement the infection control programme. Training records sighted and interview verified the ICN attends regular ongoing training.
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.	FA	The infection control programme includes policies and procedures which are current and signed off by the quality coordinator and the facility manager. Staff interviewed verifies knowledge of infection control policies. Staff are observed to be compliant with generalised infection control practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all	FA	Interviews, observation and documentation verify staff have received education in infection control and prevention at orientation and ongoing education sessions. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of

service providers, support staff, and consumers.		attendance is maintained. Audits are undertaken to assess compliance with expectation. Resident education occurs in a manner that recognises and meets the residents' and the families' communication style, as verified by resident and family interviews.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	In line with the infection prevention and control policy and procedures, monthly surveillance is occurring. These are collated each month and analysed to identify any significant trends or possible causative factors. Incidents of infections are presented to the registered nurse, team leaders, care giver and management meetings every month with written reports to the facility manager, quality coordinator and the general manager. Any ongoing actions required are presented and any necessary corrective actions discussed, as evidenced by meeting records, infection control records and staff interviews. Any immediate action required is presented to staff at hand over. Incidents of infections are benchmarked internally based on previous facility records. A comparison is used to analyse the effectiveness of the programme. The facility was concerned following two Norovirus outbreaks in close succession and requested input from an infection control consultant; however no specific reason could be found as to a possible cause for this.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint minimisation and safe practice policies and procedures have been revised since the last on site audit. They are current and have been developed following the organisation's processes for review of documents. The documents provide clear guidance to staff in the provision of the safe use of restraints when these are necessary, the use of enablers is voluntary and there is an active focus on the minimisation of restraint use. Staff receive training in restraint minimisation and safe practice through orientation and the annual training programme. A range of staff recalled their restraint and enabler training and understood the requirements of their different roles. At the time of this audit 10 residents were using restraints and four were using enablers. The residents using enablers were all involved in the assessment process and the equipment promotes their safety and independence. All appropriate documentation is in place and the process used includes informed consent and an emphasis on regular reviews to ensure the intent of these standards is met.

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.	FA	The restraint coordinator's role is detailed in the position description of the registered nurse who holds this position. At interview she describes her responsibilities, which are consistent with the functions seen on documents reviewed. The role description is noted on review of the personnel file sampling of her file. The facility and general manager and quality coordinator and the restraint coordinator make up the restraint approval group and meeting minutes include discussion of restraint minimisation and safe practice issues.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The assessment process includes all requirements of this standard and the files reviewed (four of the 10 residents using restraints and the four residents using enablers) have had an assessment completed. The assessment of restraint use includes input from a resident's family/whanau and is completed by the nursing staff who know the resident best and the restraint coordinator. Approval is given by the restraint coordinator and management team acting as the restraint approval group.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The assessment process includes providing the alternative options explored when considered use of a restraint. Review of the files and interview with the restraint and quality coordinator confirmed that restraint use is a last resort option. There are only four approved restraints in use at Ranfurly and all have a separate protocol for safe use which is incorporated into the resident's care plan when that restraint is approved for use. All four files reviewed for people with approved restraints had the relevant protocols within their care plan, as well as the other required documentation. Files reviewed, and the restraint register, demonstrate that only the approved restraints are in use. No other types of restraint are used. The restraint register is updated on a monthly basis to reflect any changes to restraint use, discontinued use or new assessments and approvals. The register was reviewed for 2015 and reflected changes. It was updated to reflect resident movements and changes in need, and was referenced against the management team minutes and resident files sampled.

Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint use is monitored by staff when in use. Monitoring forms record this and most restraints have half hourly monitoring checks throughout the day and two hourly monitoring at night. All files reviewed (both for residents using restraints and enablers) had current monitoring charts. Six monthly review of each resident's restraint includes consideration of whether the restraint can be discontinued. On one of the files reviewed a residents was being trialled without the restraint (a brief belt) with appropriate safeguards in place. The review form recorded the discussion with family and nursing staff, option considered and planning for the trial removal of the restraint. Monitoring of the trial was being gathered to enable an informed decision at the end of the seven days. (The onsite audit occurred during the trial period). At interview with the restraint coordinator she reported that their practice was to consider the option of removing the restraint at each review and exploring the options for this. Some residents using restraints were able to be involved in the discussion but most were not, however all had family/whanau members who were. One family interviewed has a family member using a restraint. This has been recently reviewed and the resident's spouse confirmed at interview that they are comfortable with the restraint being used. Documents on file record the review process and the family member's input. On all the eight files reviewed there are regular six month reviews occurring. The restraint register and restraint minimisation section in the management team meetings also reflect regular evaluation and six monthly review of restraint and enabler use.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	As part of its review of the restraint minimisation and safe practice policy and procedures the restraint and quality coordinators have also updated their quality review and reporting of their use of restraints and enablers. An internal audit of restraint minimisation and safe practice was completed in July, after the implementation of the new policy and procedures. The results demonstrate good compliance with the new system as well as maintaining numbers of restraint use rather than increase in frequency with increase in resident numbers. Review of the internal audit results with the quality coordinator occurred during the audit. There is appropriate ongoing focus on reduction in restraint use in line with the organisation's philosophy stated in their policy and reflected in interviews with staff members. The internal audit will be repeated in December 2015. There are now regular monthly reports with collated data on the use of restraints and enablers which meet the requirements of these standards. Overall the use is low given the total number of residents, however the benchmark set in the Ranfurly quality plan has not yet been reached.

		The management team meeting minutes include review of internal audit results and the monthly reports and associated graphed data. The range of activities evident confirm that there are effective systems for monitoring and quality review of restraint use.

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Negligible	The needs, outcomes and goals of residents are identified via an assessment process and documented to serve as the basis for care planning; however new residents admitted after 1 July 2015 do not have their care planning informed by the use of the interRAI assessment tool.	The requirement to use the interRAI assessment tool after 1 July 2015 to inform care planning is not being met.	Evidence is provided that the interRAI assessment tool is being used to inform care planning. 180 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
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.	CI	Quality initiatives are developed in response to identified areas requiring improvement. These range from concerns raised by residents about the quality and enjoyment of meals, monitoring call bell response times and the palliative care suites to better support residents and their family/whanau at end of life. All initiatives have been documented and those which are completed have a formal review. The reviews and outcome of each initiative is discussed at the monthly management meeting when the quality plan is discussed as part of monitoring and tracking progress against the quality plan.	Quality initiatives are identified and implemented. Once completed a formal review is conducted which includes consideration of improvement in service delivery as a result of the initiative. All initiatives are discussed and evaluated at the monthly management meetings. This initiative overall enables improvements in service delivery to be the ongoing focus of the staff and management team. Interview with a range of staff members identify that they are able to make improvements to anything which is identified as requiring improvement and they showed pride in the initiatives which have been implemented to date. The results of a range of initiatives demonstrated a focus on continuous

			improvement.
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.	CI	In December-2014 a potential risk related to hand written medication charts was identified. Residents were frequently requiring changes in medications by the GP, who was not on site. The frequent changes and faxing of updated drug charts made charts difficult to read. There was a potential for medication errors in dispensing and administration related to several versions of a medication chart being in existence and charts being illegible with numerous changes being made. The decision was made to explore the option of using an electronic medication management system with the aim of: 1) Minimising the potential for medication errors by ensuring each residents medication chart is current, contains only current medications and is legible. 2) To increase the opportunity for GPs to quickly and easily update medication charts. 3) To enable only one medication chart to be active. The system was implemented in January-2015. A review in 1-March-2015 verified all the aims of the project had been achieved. Each resident's medication chart is current, contains only current medications and is legible. GPs are able quickly and easily update medication charts. Only one medication chart per resident is active	A quality initiative was developed in December-2014 in response an identified potential risk to residents related to the use of hand written medication charts.
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes	CI	A model of care was implemented in the dementia unit that focussed the planning of the care provided around the unique needs of the individual resident, within a supportive environment that meets residents' diverse needs and respects each resident's values and experiences. Residents care plans focus on this model when describing the required support to achieve the desired outcomes. Staff received training on the care model, and this is	A quality initiative was developed that focussed the planning and implementation of care in the dementia unit, around the unique needs of the individual.

identified by the ongoing assessment process.		incorporated into staff orientation packages. The model provides the framework for how the unit operates. The results of an audit indicate that practices in the unit are consistent with the requirements of the model. An evaluation of the effectiveness of the model is evident by observation, interview, and documentation. Episodes of challenging behaviour have reduced to virtually being non-existent as has the requirement for residents to require PRN (as required) medication to be prescribed. Staff are observed assisting clients carrying out daily chores, in a peaceful environment of mutual respect.	

End of the report.