

# Ranfurly Manor Limited - Ranfurly Residential Care Centre

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## 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:

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| <b>Legal entity:</b>  | Ranfurly Manor Limited  |
| <b>Premises audited:</b>  | Ranfurly Residential Care Centre  |
| <b>Services audited:</b>  | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| <b>Dates of audit:</b>  | Start date: 24 September 2018    End date: 26 September 2018  |
| <b>Proposed changes to current services (if any):</b>   | None  |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 131   |

# Executive summary of the audit

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

## General overview of the audit

Ranfurly Residential Care Centre provides dementia, rest home and hospital level care for up to 158 residents. The service is operated by a private company and managed by a facility manager and a clinical manager and supported by the company's general manager. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, and a general practitioner.

This audit has resulted in three areas requiring improvement relating to: management position descriptions, first aid trained staff and activity plans.

## Consumer rights

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| 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. | Green | Standards applicable to this service fully attained. |
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

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| 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. |  | Some standards applicable to this service partially attained and of low risk. |
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Ranfurly Manor Limited's business, quality and risk management plans include the vision, philosophy, corporate commitment, principles of care and service goals of the organisation. Monitoring of the services provided to the owner director is regular and effective. Ranfurly Residential Care Centre is managed by an experienced and suitably qualified facility manager and the Ranfurly Manor general manager who is also experienced and suitably qualified.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events and hazards are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

## Continuum of service delivery

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| <p>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.</p> |  | <p>Some standards applicable to this service partially attained and of low risk.</p> |
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident and their family.

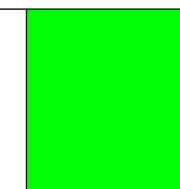
The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## Safe and appropriate environment

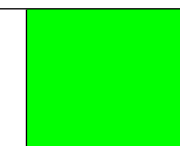
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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |
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Ranfurly Residential Care Centre meets the needs of residents and is clean and well maintained. There is a current code of compliance. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |
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The organisation has implemented policies and procedures that support the minimisation of restraint. Three residents had requested the use of enablers and seven residents had restraints in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

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| <p>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.</p> |  | <p>Standards applicable to this service fully attained.</p> |
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 0                           | 48                  | 0  | 2                                    | 0  | 0                                      | 0  |
| <b>Criteria</b>   | 0                           | 98                  | 0  | 3                                    | 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) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| <b>Standards</b>  | 0  | 0                            | 0                                      | 0                              | 0                                      |
| <b>Criteria</b>   | 0  | 0                            | 0                                      | 0                              | 0                                      |



# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

| Standard with desired outcome   | Attainment Rating | Audit Evidence  |
|---|-------------------|---|
| <p>Standard 1.1.1:<br/>Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>  | FA                | <p>Ranfurly Residential Care Centre (RRCC) has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training. This was verified in training records.</p>  |
| <p>Standard 1.1.10:<br/>Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give</p> | FA                | <p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. All files reviewed of residents in the secure unit have Enduring Power of Attorneys (EPOAs) in place and activated.</p> <p>Staff were observed to gain consent for day to day care.</p> |

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| informed consent.  |    |  |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>       | FA | <p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The manager provided examples of the involvement of Advocacy Services in relation to ongoing training and a speaker included at residents' meetings.</p>   |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | FA |  |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>                                 | FA | <p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaints process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that six complaints have been received this year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The facility manager in conjunction with the general manager is responsible for complaints management and follow up, which is undertaken the clinical manager as relevant. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There has been one complaint received from the office of Health and Disability Commissioner (HDC), since the last audit which has been responded to and remains open. No other complaints from external sources have been received since the last audit.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are</p>  | FA | <p>Residents and family/whanau interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, discussion with staff and ongoing at residents' meetings. The Code is displayed in communal areas and at the entry to the facility together with information on advocacy services, how to make a complaint and feedback forms.</p>  |

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| informed of their rights.  |    |  |
| <p>Standard 1.1.3:<br/>Independence,<br/>Personal Privacy,<br/>Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>                       | FA | <p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, arranging their own visits to the doctor, and involvement in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p> |
| <p>Standard 1.1.4:<br/>Recognition Of Māori<br/>Values And Beliefs</p> <p>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.</p> | FA | <p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers, the resident and their whanau. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs.</p>   |
| <p>Standard 1.1.6:<br/>Recognition And<br/>Respect Of The<br/>Individual's Culture,<br/>Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic,</p>  | FA | <p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed, for example support to attend church services of their choice. The resident satisfaction survey confirmed that individual needs are being met.</p>  |

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| cultural, spiritual values, and beliefs.  |    |  |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>              | FA | <p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>  |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>  | FA | <p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psycho-geriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the organisations commitment to ongoing interRAI training for RN's including attendance at update days.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular or urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents being able to speak English.</p>  |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation</p>   | FA | <p>The Ranfurly Manor Limited business plan, which is reviewed annually, outlines the vision, philosophy, principles of care, service goals and corporate commitment of the organisation. The document describes annual and longer term objectives and the associated operational plans for all three facilities within the group. A sample of monthly and quarterly reports to the general manager showed adequate information to monitor performance is reported including staffing, occupancy, financial performance, emerging risks and issues. The general manager describes</p>  |

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| <p>ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>  |           | <p>providing regular verbal reporting to the owner who is the sole director of the business, and a monthly face to face governance meeting.</p> <p>The two facilities which constitute the Ranfurly Manor group are managed by a general manager. Ranfurly Residential Care Centre is managed by a facility manager who is a registered nurse with a current annual practicing certificate and has been in this role for six months. The facility manager has previous experience as both a facility manager and as a clinical manager in aged care facilities. Responsibilities and accountabilities are defined in a job description and individual employment agreement. Both the GM and the facility manager confirm knowledge of the sector, regulatory and reporting requirements and maintain currency through the DHB aged care forum and ongoing education.</p> <p>Ranfurly Residential Care Centre holds contracts with the Mid Central district health board (DHB), Accident Compensation Corporation (ACC) and the Ministry of Health (MOH). The MOH contract is for young people with physical disabilities (YPD), and the DHB contracts are for aged residential care services including respite, chronic medically ill (CMI), daycare and hospital recovery (HRB).</p> <p>On the day of audit 131 people were receiving services. 47 were receiving rest home services, 63 were receiving hospital level services and 21 residents were receiving dementia care. This is an additional one resident in the dementia service since the last audit.</p> <p>One person was receiving hospital level care under the ACC contract. Three residents were receiving services under the MOH YPD contract; one in the hospital and two in the rest home. One palliative care resident was receiving services under the CMI contract, one person was receiving daycare services and one services under the HRB contract. 31 residents in either the rest home or the hospital were private paying. 45 people residing in either the rest home or the hospital have occupier rights agreements (ORA) at the time of audit.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>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.</p> | <p>FA</p> | <p>When the facility manager is absent the general manager or clinical manager carries out all the required duties under delegated authority. During absences of the clinical manager, the clinical management is overseen by the team leader of the dementia unit and/or the facility manager, both of whom are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>  |

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| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | <p>FA</p> | <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, both a regular resident and a regular family satisfaction survey, monitoring of outcomes, clinical incidents including skin tears, infections, medication errors, falls and restraint use.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meeting, team leader meeting, health and safety/quality meeting, qualified nurses meeting, team meeting and caregiving staff meetings. Staff reported their involvement in quality and risk management activities through use of the accident, incident management system (AIMS), audit activities, policy revision and resident survey feedback. Relevant corrective actions are developed, implemented, documented and signed off to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent surveys in April 2018 showed mixed responses which resulted in a comprehensive corrective action plan which includes sharing the results with all residents, families and staff. Results were 97% for being treated with respect and dignity and 'staff are approachable and friendly'. Areas for improvement identified by residents included the need for an increased range of activities, issues with call bell response times, feedback on the meals, staff communication, and laundry. Corrective actions have included one on one meetings with a specific resident and their family member to address specific complaints, advertising for volunteers to assist with additional activities, a call bell audit to validate family concerns, involving one resident in cooking, review of orientation package to include resident rights, communication training, appointment of a housekeeping/laundry supervisor and a review of cleaning schedules.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The GM and facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Both the GM and the facility manager are familiar with the Health and Safety at Work Act (2015) and have implemented requirements.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and</p>   | <p>FA</p> | <p>Staff document adverse and near miss events on an accident and incident monitoring (AIM) form. A sample of AIM forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the general manager as part of the monthly management reporting and meeting process.</p> <p>Both the GM and the facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been several notifications of significant events made to the Ministry of Health since the previous audit and copies of these were sighted.</p>   |

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| <p>reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>  |               |  |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>PA Low</p> | <p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained, except regarding the specific role descriptions.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Two staff members are internal assessors for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Registered nurses are available 24/7 to residents across the facility including those with Occupation Rights Agreements. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p> <p>Areas for improvement have been identified regarding current job and role descriptions being filed within staff personnel files and a system to ensure staff with current first aid certification are readily identified on the roster.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>       | <p>FA</p>     | <p>There is a documented and implemented process for determining staffing levels. Managers use the template within the electronic rostering system to ensure each roster has skill mixes to provide safe service delivery 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. There are an adequate number of RNs who are interRai trained and competent to perform assessments. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed such as for infection prevention and control advice. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of rosters over the previous four weeks confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. There is 24/7 RN coverage onsite at the facility, in the hospital. At least one staff member on duty has a current first aid certificate although this was not indicated on any of the rosters</p>   |

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|   |    | reviewed (See 1.2.7).  |
| <p>Standard 1.2.9:<br/>Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>        | FA | <p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>   |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | FA | <p>Residents enter the secure unit when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. All resident files reviewed in the secure unit evidence specialist referral to the service is confirmed.</p> <p>Residents enter the rest home and hospital service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from NASC, GP and other health disciplines for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p> <p>RRCC has contracts to provide rest home, hospital, rest home dementia, young persons with a disability (YPD), and respite care. On the day of audit there were 47 residents receiving rest home care, 63 hospital level residents and 21 residents receiving dementia level care.</p> |
| <p>Standard 1.3.10:<br/>Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and</p>  | FA | <p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute</p>  |



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| <p>coordinated transition, exit, discharge, or transfer from services.</p>   |           | <p>care facility showed all documentation completed. Family of the resident reported being kept well informed during the transfer of their relative.</p>  |
| <p>Standard 1.3.12:<br/>Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | <p>FA</p> | <p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the days of audit. The staff observed administering medications demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided monthly and on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's electronic details on commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistent.</p> <p>There are three residents who self-administer medications (inhalers) at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p> |
| <p>Standard 1.3.13:<br/>Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service</p>                              | <p>FA</p> | <p>The food service is provided on site by a chef and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Manawatu District Council 17 October 2017. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food</p>   |

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| <p>is a component of service delivery.</p>   |           | <p>handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> <p>Residents in the secure unit have access to food at any time night or day. A small kitchenette is in the unit. The fridge, cupboards and pantry are observed to be well stocked. Evidence of availability of food for residents at any time is supported by staff and family interviews.</p> |
| <p>Standard 1.3.2:<br/>Declining Referral/Entry To Services</p> <p>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.</p> | <p>FA</p> | <p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed, and a file reviewed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>  |
| <p>Standard 1.3.4:<br/>Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>   | <p>FA</p> | <p>Information is documented using validated nursing assessment tools such as the interRAI, pain scale, falls risk, skin integrity, nutritional screening and continence, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of 15 trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.</p>   |
| <p>Standard 1.3.5:<br/>Planning</p> <p>Consumers' service</p>  | <p>FA</p> | <p>Care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p>  |

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| <p>delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>   |               | <p>Plans evidence service integration with progress notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff as observed during the audit. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> <p>The care plans of the residents' files reviewed in the secure unit, reflected the support needs of the residents. All resident files reviewed have behaviour management plans in place that identify the specific behaviours residents exhibit, the triggers, if any, to those behaviours and the management strategies required to manage those behaviours. Behaviour monitoring charts monitor any events to enable a review of the effectiveness of the management strategies.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>  | <p>FA</p>     | <p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. These were very detailed, individual and easy to follow.</p> <p>The GP interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a very good standard. Care staff confirmed that care was provided as outlined in the documentation.</p> <p>A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>   |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>PA Low</p> | <p>The activities programme is provided by a trained diversional therapist, with the assistance of a recreation officer. A planned weekly programme is in place for all services in the facility.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements, however there is no individualised activities plans in place in the secure unit, the rest home or hospital service that identifies the individuals' specific activity interventions and goals and this requires improvement.</p> <p>Activities assessments are regularly reviewed to help formulate an activities programme. The resident's activity needs are evaluated regularly as part six monthly care plan review.</p>   |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>  | <p>FA</p>     | <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. A handover (observed) reports changes between shifts.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating</p>  |

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| <p>evaluated in a comprehensive and timely manner.</p>  |           | <p>changes to the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, wounds, mobility, behaviour and continence. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. They were consistently complimentary of the level of feedback provided.</p> <p>The GP confirmed he is kept informed in a timely manner with regular reviews of residents' status.</p>  |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | <p>FA</p> | <p>Residents are supported to access or seek referral to other health or disability service providers. Although the service has a 'house practice', residents may choose to use another medical practitioner from another practice. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the local hospital consultants.</p> <p>The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. A file reviewed provided confirmation of the process.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>                      | <p>FA</p> | <p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. The maintenance person is booked into training to become a designated chemical handler this year. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored such as the laundry and housekeepers' storeroom. Staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>   |
| <p>Standard 1.4.2: Facility</p>   | <p>FA</p> | <p>Ranfurly Residential Care Centre was originally built in 2013 and extended in 2014/15. A current certificate for</p>   |

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| <p>Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>   |    | <p>public use (expiry date 19/10/2018) is publicly displayed at reception.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p> | FA | <p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes all rooms having their own toilets, shared showers located in the corridors and full ensuites in the apartments. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>  |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>   | FA | <p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation and the apartments allow for shared accommodation. Where apartments are shared, this is at the request of the residents. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>   |

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| <p>Standard 1.4.5:<br/>Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | <p>FA</p> | <p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents and their visitors can access areas for privacy, if required, both in their own rooms and in various seating areas within the facility and in the garden. Furniture is appropriate to the setting and residents' needs.</p>  |
| <p>Standard 1.4.6:<br/>Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>                     | <p>FA</p> | <p>Laundry is undertaken on site in a dedicated laundry and by family members as requested. Some washing such as woollens is dried on the washing line in the garden. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. These staff are undertaking or have completed the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through monthly auditing as part of the internal audit programme, and feedback from the GM and residents</p>  |
| <p>Standard 1.4.7:<br/>Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>  | <p>FA</p> | <p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. This includes full photographic depiction of emergency actions which may be required for shutting off or restarting equipment. Comprehensive disaster and civil defence planning guides direct the facility staff in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The local DHB Pandemic Plan is available should this be required. The current fire evacuation plan was approved by the New Zealand Fire Service on 5 November 2013. A trial evacuation takes place six-monthly under the direction of a contracted fire expert, with a copy sent to the New Zealand Fire Service, the most recent being In August 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures, including the planned evacuation from one fire cell to another.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile</p> |

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|   |    | <p>phones and gas BBQ's were sighted and meet the requirements for the 131 residents. Water storage tanks are located around the complex, and there is a generator readily available.</p> <p>Call bells positioned throughout the facility alert staff to residents requiring assistance. Call system audits are completed, and issues are followed up. Residents and families reported staff respond to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and staff check the premises at night.</p>   |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>                      | FA | <p>All residents' rooms, apartments and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and many have doors that open onto outside garden areas. All residents have easy access to external well maintained courtyards. Heating is provided by underfloor heating in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>   |
| <p>Standard 3.1: Infection control management</p> <p>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.</p> | FA | <p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the local hospital if required. The infection control programme and manual are reviewed annually.</p> <p>A registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the general manager and clinical manager, and tabled at the quality committee meeting. This committee includes the general manager, facility manager, IPC coordinator, clinical manager, health and safety officer, and representatives from food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been, unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p> |
| <p>Standard 3.2: Implementing the</p>   | FA | <p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for six months. She is supported by the clinical manager who has post graduate qualifications in infection prevention</p>   |

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| <p>infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>   |    | <p>and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>  |
| <p>Standard 3.3: Policies and procedures</p> <p>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.</p> | FA | <p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in January 2018 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>   |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff,</p>   | FA | <p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when an outbreak occurred in October 2017, the learning was to act at first symptoms and staff ongoing training occurs regularly.</p> |



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| and consumers.  |    | Education with residents is generally on a one-to-one basis and has included reminders about handwashing before meals and after toileting, and advice about remaining in their room if they are unwell.  |
| <p>Standard 3.5:<br/>Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager, quality committee and to the owner via the general manager. Data is benchmarked externally within the group. Benchmarking has provided assurance that infection rates in the facility are below average for their organisation.</p> <p>A summary report for a recent gastrointestinal infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p> |
| <p>Standard 2.1.1:<br/>Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>  | FA | <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility. The clinical manager demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities and those of the restraint coordinator, who was unavailable on the day of audit.</p> <p>On the day of audit, seven residents were using restraints and three residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is used for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>  |
| <p>Standard 2.2.1:<br/>Restraint approval and processes</p>   | FA | <p>The restraint approval group, made up of the management team, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the clinical and facility managers that there are clear lines of accountability, that</p>   |

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| <p>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.</p> |           | <p>all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whanau or EPOA and/or the resident's general practitioner involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p>  |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>  | <p>FA</p> | <p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whanau or EPOA. The clinical manager interviewed described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>   |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>  | <p>FA</p> | <p>The use of restraints is actively minimised and the clinical manager described how alternatives to restraints are discussed with staff and family members as relevant.</p> <p>When restraints are in use, staff interviewed described the frequent monitoring which occurs to ensure the resident remains safe. Records of monitoring sighted had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed as part of the management reporting and meeting process. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as VIPS that is Value /Individual/ Perspective / Social communication skills, which indicates how to positively support people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p> |

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| <p>Standard 2.2.4:<br/>Evaluation</p> <p>Services evaluate all episodes of restraint.</p>   | <p>FA</p> | <p>Review of the seven residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and monthly through the management reporting system. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>   |
| <p>Standard 2.2.5:<br/>Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p> | <p>FA</p> | <p>Restraint use is monitored by the restraint coordinator, reported on monthly to the management team using the restraint/enabler monthly report and annually using the annual report template. Progress against restraint minimisation targets set within the annual plan are monitored monthly.</p> <p>The regular review of all restraint use includes all the requirements of this Standard. Individual use of restraint use is reported monthly to the quality and health and safety and relevant staff meetings. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint/enabler education and feedback from the doctor, staff and families. Internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with managers and staff confirmed that the use of restraint has been reviewed and there is culture of restraint minimisation within the organisation.</p> |

## 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)   |
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| Criterion 1.2.7.2<br>Professional qualifications are validated, including evidence of registration and scope of practice for service providers. | PA Low            | Two key senior staff and one manager did not have a copy of their current position or role description filed within their personnel file. The restraint coordinator’s responsibilities are documented within the restraint minimisation policy along with the responsibilities of other relevant staff such as the facility manager and references were made to the responsibilities within the person’s recent performance review. The facility manager had a copy of the role description for another smaller facility owned by the same company but not the current position held. No copy of the infection control role was evidenced within the file of the staff member holding this role. Best practice requires managers and staff to have copies of their roles and responsibilities documented, available to them and filed within their personnel file. | The facility manager, restraint co-ordinator and infection control co-ordinator do not have a current position description for their role. | Ensure all staff have documentation on file which reflects their current position and/or specific roles they hold.<br><br>180 days |
| Criterion 1.2.7.5<br>A system to  | PA Low            | A list of staff with current first aid certification and another of staff without was available on the day of audit, however neither list was linked to the  | There is no system to easily identify that there is  | Create a simple system   |

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| <p>identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>   |               | <p>rostering process to ensure there was always a staff person with a current first aid certificate on duty.</p>  | <p>at least one first aid trained staff member on site at all times.</p>  | <p>to indicate the first aid certification status of staff within the roster, to ensure there is always at least one first aid trained staff onsite.</p> <p>180 days</p>                        |
| <p>Criterion 1.3.7.1<br/>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p> | <p>PA Low</p> | <p>Files reviewed of residents in the secure unit had an initial assessment undertaken on admission that included the residents' social profiles, past interests, strengths and skills. A tick sheet summarised the residents generalised activity interests. The evaluation on the summary referred to residents' participation in the activities that had been ticked. The same format was reflected in activity forms in the hospital and rest home service.</p> <p>There was no activity plan, that identified the specific interests, strengths or goals of each resident, nor the specific interventions required to meet the goal in all service areas. No reference to meeting the resident's twenty-four-hour needs in the dementia service was recorded.</p> <p>Interviews with the staff verified activities were offered at any time if the residents required these. If residents were awake at night, activities, food and fluids were offered. During the day activities were noted to be accessible to residents, for example puzzles on tables, drawings, fiddle boards.</p> | <p>There are no documented activities plan for each individual resident in the secure unit, rest home or hospital service that identifies the specific individualised activities required to meet the holistic needs of the resident. There is no activity plan over a twenty-four-hour period for residents in the dementia service.</p> | <p>An individual activity plan is developed that identifies specific recreational needs for all residents, and over a 24-hour period for residents in the dementia service.</p> <p>180 days</p> |

## Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.