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 - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 5 October 2021 End date: 6 October 2021

Proposed changes to current services (if any): The provider is currently building 10 new apartments as an extension to the existing facility. They are at the framed stage and not completed sufficiently to be included in this report.

Total beds occupied across all premises included in the audit on the first day of the audit: 132

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 certified to provide rest home, hospital and dementia level care for up to 164 residents. The facility is owned by Ranfurly Manor Limited and is managed by a facility manager with support from a clinical and quality manager and general manager.

Residents and families reported high satisfaction with 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, families, managers, staff and a nurse practitioner.

An email was received from the District Health Board a day prior to the audit. The email related to an incident report that had been entered into the District Health Board's electronic system by the district nursing service. The incident report concerns the care of a resident under an Accident Compensation Corporation contract. The resident's file was reviewed, and details are recorded in the body of this report using tracer methodology.

A continuous improvement rating has been awarded relating to providing an environment for residents who are transitioning from the dementia unit to hospital level care. There are no areas requiring improvement from this audit.

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.		All standards applicable to this service fully attained with some standards exceeded.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Ranfurly Residential Care Centre when they are admitted and is well displayed thoughout the facility in both English and te reo Māori. Opportunities are provided to discuss the Code, consent, and availability of advocacy services at the time of admission and thereafter as required.

Services at Ranfurly Residential Care Centre are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed to be interacting with residents in a respectful manner.

Care for any residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

Ranfurly Residential Care Centre has linkages to a range of specialist health care providers, all of which contribute to ensuring services provided to residents are of an appropriate standard.

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

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 Manor Limited is the governing body and is responsible for the services provided. A business plan includes a vision, principles of care and goals. Quality and risk management systems are fully implemented at Ranfurly Residential Care Centre and documented systems are in place for monitoring the services provided, including regular reporting by the facility manager to the general manager who reports to the governing body.

The facility is managed by an experienced and suitably qualified manager. The facility manager is supported by an acting clinical and quality manager and a general manager. The managers are all registered nurses. The acting clinical and quality manager is supported by three team leaders/registered nurses and is responsible for oversight of the clinical services.

An internal audit programme is in place. Adverse events are documented on accident/incident forms electronically. Corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Quality, health and safety, management, and various staff and residents' meetings are held on a regular basis.

Actual and potential risks, including health and safety risks, are identified and mitigated.

Policies and procedures on human resources management are in place and followed. Staff have the required qualifications. An in-service education programme is provided, and staff performance is monitored.

A documented rationale for determining staffing levels and skill mix is in place. Registered nurses are always rostered on duty. The facility manager, clinical and quality manager and team leader are rostered on call after hours.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained using integrated electronic and hard copy files.

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.		Standards applicable to this service fully attained.

Access to the facility is appropriate and efficiently managed with liaison evident between Support Links and the clinical team. Relevant information is provided to the potential resident and their family to facilitate admission to the facility.

The residents' needs are assessed by the multidisciplinary team on admission and within the required time frames. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. The residents' files reviewed evidenced that the care provided, and the needs of the residents are reviewed and evaluated on a regular and timely basis. Residents are referred to other health providers as required. Shift handovers and communication sheets promote continuity of care between the shifts in each of the clinical areas.

The planned activity programme is delivered by one full time diversional therapist and two part time activities assistants. The programme provides the residents with a variety of individual and group activities and maintains their links with the community. There is a facility van available for outings.

Medicines are managed according to the policies and procedures which are based on current best practice and consistently implemented. Medications are administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with any special requirements catered for. Policies guide the food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with the meals provided.

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.

A building warrant of fitness is displayed at the front entrance. Preventative and reactive maintenance programmes include equipment and electrical checks.

Rooms and apartments have ensuites. Adequate numbers of additional bathrooms and toilets are available. Several lounges, dining areas and alcoves are available. Shaded external areas and sitting are provided.

An appropriate call bell system is available, and residents reported timely responses to call bells. Security and emergency systems are in place. Staff are trained in emergency procedures and emergency resources are readily available. Emergency supplies are checked regularly. Fire evacuation procedures are held six monthly.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is laundered on site. Cleaning and laundry processes are evaluated for effectiveness.

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.

Ranfurly Residential Care Centre has policies and procedures in place that meet the requirements of the restraint minimisation and safe practice standard. There were eight residents using a restraint and two residents using enablers at the time of audit. Restraint processes in place meet the standards.

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 infection prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed if required.

Staff demonstrated good knowledge around the principals and practice of infection control, guided by relevant policies and supported with regular education.

Age care specific infection surveillance is undertaken, with data analysed, benchmarked and results reported through to 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)
Standards	1	49	0	0	0	0	0
Criteria	1	100	0	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	Ranfurly Residential Care Centre (Ranfurly) has policies, procedures, and processes in place 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 part of the ongoing yearly training programme, as was verified in training records and the training calendar.
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	Nursing and care staff interviewed understood the principals and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs and outings. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents is defined and documented, as relevant, in the residents' record. Staff demonstrated their understanding by being able to explain situations when this may occur. All residents' files reviewed in the Dementia facility have an EPOA in place and these have been activated. There were no residents in the secure unit with English as a second language. Interpreter services by Mid/Central DHB are on display. One resident in the unit identified as

		Maori and their specific cultural needs are detailed in their care plan. All families were well informed as per the family communication sheets, incident forms and interviews. Staff were observed gaining consent for day-to-day care on an ongoing basis.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents, family and whanau are given a copy of the Code in the admission pack which also includes information on the Advocacy Service. Posters and brochures related to the service are on display and available throughout the facility. Family members and residents spoken to were aware of the Advocacy Service, how to access this and their rights to have a support person. Staff are also aware of how to access the Advocacy Service if this is required.
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 and the community by attending a variety of organised outings, visits, activities and entertainment. The facility encourages visits from family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with the staff. There are several lounges available for residents and families to utilise throughout the facility. A quiet sunny corner is available for residents to utilise away from the main lounges for privacy.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and complaints information and forms are available at the main entrances. The facility manager (FM) is responsible for complaint management and follow-up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required. Fifteen complaints have been received since the previous audit and have been entered into the complaint register. Complaint documentation was reviewed and actions taken were recorded and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible. The register shows a significant reduction in complaints for 2021. The FM stated holding a family evening was well attended and senior staff updated and discussed various activities with the families. Evaluations reviewed evidenced high satisfaction from families. Examples of this included “a big learning curve” and “found the session enlightening”. Families are also provided with quarterly

		newsletters which give good information. There is currently a complaint investigation with the Health and Disability Commissioner (HDC) relating to the care of a resident. Documentation has been requested by the HDC and this was provided by the FM on the 22 March 2021. The FM advised to date a response has not been received from the HDC. A complaint from November 2020 has been investigated by the DHB relating to the care of a resident and this has been addressed and is now closed. HealthCERT received a complaint in May 2020 which was forwarded to the DHB. The FM reported the DHB advised them of the complaint, however this was managed by the DHB and the FM stated they did not receive any more information with regards to this.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	When interviewed, the residents and family/whanau of Ranfurly Residential Care Centre (Ranfurly) reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussion with staff. The Code is displayed in English and te reo Māori throughout the facility and information on how to make a complaint and provide feedback is on display in the reception area with information on the Advocacy Service.
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	Residents and their families confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff understood the need to maintain privacy and were observed doing so throughout the audit when attending to personal cares, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussions with families/whanau and the GP. All residents have a private room. There are several lounges located throughout the facility providing quiet areas to chat away from the main communal areas. Residents are encouraged to maintain their independence by participating in community activities and often the community activity comes to them as COVID-19 restrictions allow. Each resident's care plan includes documentation related to the resident's abilities and strategies to maintain and maximise their independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs have been identified, documented and incorporated into their care plan. 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 be occurring on an annual basis.

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	There are seven residents' at Ranfurly who identify as Māori. Staff supported that residents integrate their cultural values and beliefs with their day to day activities. The principals of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whanau. There is a current Māori health plan and an option in the resident's care plan to have a culturally appropriate health plan. Guidance on tikanga best practice is available and there are staff who identify as Māori in the facility and provide a knowledgeable resource for staff.
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	Residents and their families verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Residents' personal preferences required interventions and special needs were included in all care plans that were reviewed. For example, likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction survey confirmed that the resident's individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed, confirmed that residents were free from discrimination, harassment or exploitation and felt safe. The nurse practitioner also expressed satisfaction with the standard of services provided to the residents. The induction process for staff includes education related to professional boundaries and expected behaviour to support good practice. 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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	A continuous improvement rating has been awarded for a quality initiative relating to residents in the dementia unit transitioning into hospital level care. The service provides and encourages good practice through evidence-based policies, input from external specialist services and allied health professionals, for example hospice, wound care specialists, dieticians, podiatrists, and education for staff. The NP confirmed that the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Ongoing yearly training for RNs and care staff is provided in house and from external providers as COVID allows. There is a very robust and thorough education

		programme which showed clear evaluation of sessions.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their own or their relative's status, they are advised in timely manner about any incidents or accidents and the outcomes of regular or urgent medical reviews. This was clearly documented in the residents' records that were reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principals of open disclosure, which is supported by education, policies and procedures that meet the requirements of the Code. Staff knew how to access an interpreter service and there are also members of staff who are bilingual.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Ranfurly Manor Limited employs a general manager (GM) who has oversight of the facilities within the group. The business plan 2021-2022 includes a vision, philosophy, principles of care, service goals and corporate commitment. The business plan is reviewed annually. Reports are provided to the GM who reports to the governing body. The reports are a summary of all activities undertaken in the facility including quality, infection control, education, occupancy and staffing, complaints and finances. Review of the reports and interview of the FM confirmed this. The facility is managed by an experienced FM who is an RN and has been in the position since 2017. The FM attended a business and leadership conference in 2020 and is currently completing a level six (NZQA) diploma in business. The management of clinical services is the responsibility of the acting clinical and quality manager (ACQM) who is an experienced FM/RN and is fulling the role in a temporary capacity while the current CQM is providing clinical support in another of the group's facilities. The annual practising certificate for the AQCM was current. There was evidence in the AQCM's file of keeping up to date clinically. Ranfurly Residential Care Centre has contracts with the local DHB, MoH and ACC. On the first day of the audit, 132 residents were receiving services. Aged related residential care contract - 113 residents (60 hospital level including residents in the care suites under an occupation rights agreement, 53 rest home level including residents under an occupational rights agreement, and 19 residents receiving dementia level care). Residential-non aged contract – 10 (2 over the age of 65 years and 8 under the age of 65 years, all hospital level care). Complementary care Services contract-respite –2 rest home level resident. Hospital recovery – 3 residents, chronic

		conditions x 1 hospital level resident and ACC individual contracts-3 residents. All beds have been approved as dual purpose apart from the beds in the dementia unit.
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	The FM and CQM work fulltime with team leaders/RNs in the three services. When the FM is temporarily absent, the CQM fills the role with support from the GM. If the CQM is temporarily absent, the FM fills the role. The FM and acting CQM reported this arrangement works 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	A quality assurance and risk management plan guides the quality programme. Quality systems are well embedded at Ranfurly. Service delivery is linked to quality and risk throughout a number of documents including health and safety, clinical incident and accidents and infection control. The senior management team meet monthly to discuss a variety of topics including quality and risk. Resident, quality / health and safety, RN, and staff meetings are held regularly and evidenced good reporting of clinical indicators, and any trends and discussions around corrective actions. Meeting minutes reviewed were comprehensive with people responsible for any corrective actions, timeframes for completion and sign off. Any corrective actions not completed are brought forward to the following meeting. The audit programme for 2021 and completed audits were reviewed. Resident and family surveys for 2020 evidenced satisfaction with the service provided, with increased satisfaction compared to the previous year in some areas. Interviews of residents and families confirmed this. Quality data is entered electronically. Data is collated and analysed to identify any trends. Corrective actions are developed and implemented for deficits identified. Various graphs showing quality data trends are generated annually and month by month graphs are available for staff in the staff room. Monthly quality reports are provided to the GM by the CQM and evidenced a wide variety of quality data is reported on. The organisation uses a quality programme provided by an external company. All documents are controlled. They are relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Staff receive updated policies in a folder to read and these are also held electronically. Obsolete documents are archived electronically, and hard copies are put into a secure bin for destruction.

		Hazards are recorded in the hazard register and newly found hazards are communicated to staff and residents as appropriate. Staff confirmed they understood what constituted a hazard and the process around reporting. Actual and potential risks are identified and documented in the risk register, including risks associated with human resources management, legislative compliance, contractual risks and clinical risk and showed the actions put in place to minimise or eliminate risks. A maintenance person is the new health and safety representative and although they have knowledge of health and safety matters, they stated they will be completing a health and safety update online.
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	Adverse, unplanned or untoward events are documented by staff on incident/accident forms electronically. These are reviewed by the RNs on duty and forwarded to the team leaders who investigate and implement any corrective actions required. The CQM checks and closes out all incident/accidents. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition. Policy and procedures comply with essential notification reporting. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. The ACQM reported there have been five section 31 notifications to HealthCERT since the previous audit consisting of four pressure injuries and one death of a resident referred to the coroner.
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	Policies and procedures relating to human resources management are in place. Staff files reviewed included job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting. The orientation programme is robust and includes a comprehensive orientation book for both nonclinical and clinical staff with competencies. All new staff are required to complete this. The workbook is completed within three months of employment. Staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers all essential

		components of the service provided. In-service education is provided for staff using several methods, including repeated one-hour sessions over five days provided at different times to give all staff the opportunity to attend. 'Toolbox talks' have been introduced to try and improve attendance numbers. The local DHB and hospice also provide an education programme for RNs and staff attend other external education. Individual records of education are held electronically. Competencies were current including medication management and restraint. Attendance records are maintained. Of the 25 RNs, 12 are interRAI trained and have current competencies. All RNs, some care staff and others including the activities staff have current first aid and CPR certificates, 56 staff in total. All care staff in the dementia unit have attended level 4 (NZQA) - dementia specific modules. All care staff working in the rest home/hospital areas have either completed or are enrolled to complete the training. A New Zealand Qualification Authority (NZQA) education programme (Careerforce) is available for staff to complete, and they are encouraged to do so. Two team leaders are Careerforce assessors. Eleven HCAs have attained level 2, with five enrolled, eight have attained level 3, with six enrolled and eight have attended level 4 with one enrolled. Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice. Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.
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 and implemented process for determining staffing levels and skill mixes to provide safe service delivery. Staffing levels are reviewed constantly to meet the changing needs of all residents, skill mix and the layout of the physical environment. The senior management team are on call after hours. Care staff reported there is adequate staff available to complete the work allocated to them. Residents and families interviewed confirmed this. Observations during the audit confirmed good staff cover is provided. Observations and review of rosters confirmed adequate staff cover is provided, with staff replaced in any unplanned absence. The FM reported that, should there be a need where a change in residents' health status requires this, part time staff cover extra hours and there is a casual RN as well to call on. The senior managers and team leaders are experienced RNs. Two of the 25 RNs working on the floor are new graduates and the remaining RNs all have prior aged care experience ranging from two to 20 plus years. Registered nurses who have extra

		responsibilities, including completing interRAI assessments, are rostered off the floor. An extra RN is rostered on or the EN is rostered on flexible shifts as required across the facility. The dementia unit and the wings in the hospital/rest home have team leader/RNs rostered on duty 8am to 5pm. The dementia unit has three health care assistants (HCAs) on the morning shift, three HCAs on the afternoon shift and one HCA on the night shift with HCA from the hospital areas to assist as needed. The hospital/rest home areas have two team leaders/RNs plus an RN and 13 to 14 HCAs on the morning shift; three-four RNs and 13-14 HCAs on the afternoon shift; and two RNs and five HCAs on the night shift. The apartment team leader who is an experienced RN is responsible for the care provided to the residents who have an occupational right agreement. The care suites are situated within the facility and staff are included in rostering. Support staff consists of a diversional therapist, and two activities assistants, two maintenance people, a house keeping supervisor and 18 cleaners and laundry staff. The kitchen has a kitchen supervisor and 11 cooks/kitchen hands.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	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/NP and allied health service provider notes. This includes interRAI assessment information which is entered into the Momentum electronic database. Records are legible with the name and designation of the person stamped beside the entry. Archived records are held securely off site and are readily retrievable. Residents' records are held for the required period before being destroyed. No personal or private resident information was on display during the audit.
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	Residents are admitted to Ranfurly following assessment from the local Support Links Service, as requiring the level of care that Ranfurly provides. For those residents in Dementia care, all appropriate consents were in place and signed by the EPOA's as was the admission agreements. Specialist authorisation for placement was sighted in the files viewed. Prospective residents and their families are encouraged to visit the facility prior to admission. They are provided with written information about the service and the admission process. All residents prior to admission are screened in accordance with current COVID MOH

		guidelines. Family members interviewed stated that they were happy with the admission process and the information that had been provided to them. Files reviewed contained the completed demographic information, assessments, and signed admission agreements in accordance with the contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner. The service uses the DHB 'Pink Envelope' system to facilitate the transfer of residents to and from acute care settings. There is open communication between all services, the residents, and the family. At the time of transition between services, appropriate information, including medication records and the care plan, is provided for ongoing management of the resident. All referrals are documented in the progress notes.
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 current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. 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 administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The medications are checked against the prescription and signed in electronically by the RNs. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required. 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 with controlled drugs signed in. All registered nurses are competent with syringe drivers. The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room also had evidence of temperature records taken at the time of the audit. Good prescribing practices were noted. These included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP reviews were consistently recorded on the medicine charts. There are no standing orders or verbal orders. Vaccines are

		not stored on site. Residents and staff have received the required COVID-19 vaccines except for those who did not want to be vaccinated.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site with a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietician. 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 Ministry of Primary Industries. At the time of the audit, the kitchen was observed to be clean. The cleaning schedule was maintained. Food temperatures, including for high-risk items, are monitored and recorded as part of the plan using a paper-based recording system. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The kitchen provides a varied menu which supports residents with specific cultural food requirements. Special equipment to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals was verified by resident and families/whānau interviews, satisfaction surveys and in residents' meeting minutes. There are snacks available 24 hours a day for residents and in the dementia facility with trays of sandwiches also made. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
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	If a referral is received, but the resident does not meet the entry criteria, there are no vacancies, or the referral has been declined from the service due to inappropriate referral from Support Links, there is a process in place to ensure that the prospective resident and family are supported to find an appropriate level of care as per the declining entry policy. If the needs of the resident change and they are no longer suitable for the services offered, a referral for reassessment is made to Support Links and a new placement is found in consultation with the resident and the whanau/family.

Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	On admission, residents of Ranfurly are assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, cognition and behaviour, nutrition, activities, mobility, to identify any deficits and to inform initial care planning. Within three weeks of admission, residents (except for respite, ACC and YPD residents) are accessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require. Interviews, documentation, and observation verified the RNs are familiar with requirements for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing needs. All residents have current interRAI assessments completed by one of the trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans at Ranfurly are all electronic. When reviewed they reflected the support needs of the residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were reflected in the care plans reviewed. Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. The five electronic files reviewed in the Dementia facility each had a detailed 24 hour behavioural plan in place specific to the residents individual needs. Residents and family/whanau reported participation in the development and ongoing evaluation of care plans.
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 with residents and families verified that the care provided to the residents was consistent with their needs, goals and plan of care. The attention to meeting a diverse range of residents' needs was evident in all areas of service provision. The NP interviewed confirmed that medical orders are carried out in a timely manner and staff are very proactive at contacting the NP should a resident's condition change. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources were available and suited to the levels of care provided and in accordance with the resident's needs.

Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities programme is provided by one full time qualified diversional therapist, who is supported by a full time activities assistant in the rest home and hospital and a part time activities assistant in the dementia facility for 20 hours per week. They support the residents seven days a week Monday to Friday 9.00am to 4.30pm and Tuesday to Sunday. An activities assessment is completed on admission to ascertain the resident's needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate a plan that is meaningful to the resident. The activities are evaluated weekly to ascertain resident's likes and dislikes. A monthly 'tick list' is completed along with the progress notes all of which form part of the six-month multidisciplinary care plan review. Residents in the dementia unit have an in depth 24-hour diversional therapy plan and an assessment on admission to enable staff to better care for them and understand their needs. There are 10 residents who identify as Māori and support is given for activities culturally appropriate for them. It is the aim of the diversional therapists to get the residents engaging in the community as much as COVID-19 restrictions allow. There is a facility van available for drives on a weekly basis for rest home, hospital and dementia care residents. Activities reflected the residents' goals, ordinary patterns of life and included normal community activities, regular church services, 'Housie', knitting and visiting entertainers. There are individual, group and gender specific activities for female and male residents. Hospital and rest home residents have a separate activity programme from the dementia care residents. There are several lounge areas, as well as the individual's bedrooms where they can watch their own television or listen to the radio. The Activities Calendar is on display and each resident is given a copy of the weekly activities available for them to participate in. Residents and families can evaluate the programme through day to day discussions with the activities co-ordinator and by completing the six-monthly resident satisfaction survey. Activities are also reviewed at the six monthly multidisciplinary team meeting. Residents interviewed confirmed the programme was interesting and varied.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated each shift and reported on in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI/clinical reassessment or as the residents' needs change. Evaluations are documented by the RN. Where progress is different from that expected, the service responds by initiating changes to the plan of care. Short term care plans are consistently reviewed for infections, pain, and weight loss, and progress is evaluated as clinically indicated and according to the degree of risk noted during the

		assessment process. Other plans, such as wound management plans, were evaluated each time the dressings were changed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting 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 input. Copies of referrals were sighted in the residents' files. The resident and the family/whanau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as ringing an ambulance if the situation dictates.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Policies and procedures specify labelling requirements in line with legislation. Documented processes for the management of waste and hazardous substances are in place. Incidents are reported in a timely manner. Safety data sheets were sighted and are accessible for staff. The hazard register is current. Protective clothing and equipment were sighted that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound understanding of processes relating to the management of waste and 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	A building warrant of fitness is displayed at the front entrance that expires on the 20 August 2022. Residents and families confirmed they can move freely around the facility and that the accommodation meets their or their relative's needs. Passageways are wide and there is ample room for residents to pass comfortably in all areas. There is a proactive and reactive maintenance programme, and the buildings, plant and equipment are maintained to a high standard. Maintenance is undertaken by a team of maintenance staff who demonstrated good knowledge. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current. Hot water temperatures at resident outlets are maintained within the recommended range. There are external areas available that are appropriate to the resident groups and setting including the dementia unit. Large external courtyards with seating and shade are available for residents to frequent including secure outdoor areas for the dementia residents. The environment is conducive to the range of activities undertaken in the areas. Residents are

		protected from risks associated with being outside. Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. All rooms/care suites have access to an ensuite. Bathrooms have appropriately secured and approved handrails provided in the toilet/shower areas and other equipment and accessories are available to promote independence. Separate bathrooms for staff and visitors are available.
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	Both bedrooms and care suites are specious. Good personal space is available to allow residents and staff to safely move around in. Equipment was sighted in the rooms with sufficient space for both the equipment and at least two staff and the resident. The residents' accommodation is personalised with their own furnishings, photos and other personal possessions. Residents and families are encouraged to make the space their own and stated their rooms are suitable for their needs.
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	The facility is spacious and has numerous areas for residents to frequent. Good access is provided to the lounges and the dining room areas with residents observed moving freely. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas.
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	Cleaning and laundry policies and procedures are documented and guide services. The facility is cleaned to a high standard. There are processes in place for the collection, transportation and delivery of linen and residents' personal clothing. There are safe and secure storage areas and staff have appropriate and adequate access to these areas, as required. Chemicals were labelled and stored safely within these areas, with a closed system in place. Sluice rooms are available for the disposal of soiled water/waste. Hand

		washing facilities and gel are available throughout the facility. The effectiveness of the cleaning and laundry services is audited via the internal audit programme, spot checks, and visits from the chemical company representative. Reports from the chemical company representative and completed audits for laundry and cleaning were reviewed. All laundry is laundered on site including residents' personal clothing. Cleaning and laundry staff demonstrated a sound knowledge of processes. Residents and families stated they were satisfied with the cleaning and laundry services.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A letter from the New Zealand Fire Service (NZFS) dated 5 November 2013 approving the fire evacuation scheme was sighted. The last drill was undertaken on the 8 September 2021 and a copy sent to the NZFS. Emergency and security management education is provided at orientation and at the in-service education programme. Documented systems are in place for essential, emergency and security services. Policy and procedures document service provider/contractor identification requirements along with policy/procedures for visitor identification. Information in relation to emergency and security situations is readily available/displayed for staff and residents. Emergency equipment was accessible, current and stored appropriately. The service has a call bell system in place that is used by the residents, families and staff members to summon assistance. All residents have access to a call bell. Call bells are checked by the maintenance staff. Residents confirmed they have a call bell and staff respond to it in a timely manner. The service has documented processes for essential, emergency and security services. There is at least one designated staff member on each shift with appropriate first aid training. Staff records sampled evidenced current training regarding fire, emergency and security education. Information in relation to emergency and security situations is displayed and available for staff and residents with evidence of emergency lighting, torches, gas and BBQ for cooking and extra food supplies. Emergency water is maintained in a tank. Battery powered emergency lights and a portable generator are also available. External doors are lock automatically and are alarmed.
Standard 1.4.8: Natural Light, Ventilation,	FA	The entire facility is heated by under floor heating.

And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		Procedures are in place to ensure the service is responsive to residents' feedback regarding heating and ventilation in the facility. Residents and families confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The facility is smoke free.
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	Ranfurly Residential Care Centre implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. A comprehensive and current infection control manual is available to staff and managers. There is evidence that formal reviews of the programme are completed annually. The hospital team leader is the designated infection prevention and control co-ordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and reviewed at the monthly quality committee meetings. Infection prevention and control matters are also discussed at registered nurse meetings, staff shift handovers, staff meetings and ultimately at management meetings. The committee includes the hospital team leader, general manager, quality clinical manager and the facility manager. Signage at the main entrance to the facility is relevant to the current COVID 19 alert levels and 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 and confirmed this had been further reinforced since the COVID-19 pandemic emerged with a documented process for each of the alert levels.
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 prevention and control coordinator has the appropriate skills, knowledge and qualifications for the role. Additional support and information can be accessed from the infection control team at the DHB, the community laboratory, the GP and the public health unit, as required. The co-ordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. There is a COVID-19 management plan in place which details all the actions required by the service stream within the facility in response to each of the alert levels. The infection prevention and control coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.

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 IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policy review is ongoing and clearly documented on each policy is the next review date. 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, as was appropriate to the setting. Hand washing and sanitiser dispensers are distributed around the facility. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and in ongoing education sessions. Education is provided by suitably qualified RNs and the infection prevention and control 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 was evidence that additional staff education has been provided in response.
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	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. The infection prevention and control coordinator reviews all reported infections and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. 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 at staff meetings and during shift handovers. A good supply of personal protective equipment was available and the facility has processes in place to manage the risks imposed by COVID-19.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of	FA	Ranfurly Residential Care Centre has policies and procedures in place to guide staff in the management of restraints. There were eight residents using a restraint and two residents using enablers at the time of audit. The restraint co-ordinator demonstrated a sound knowledge

restraint is actively minimised.		relating to minimising restraint use, current and potential risks of restraint, the approval process, and monitoring and review of the restraint process. Enablers are voluntary and residents reported being able to maintain their independence. Restraint meetings are held as part of the management and quality meetings. A review of the minutes confirmed this. Required documentation relating to restraint and enabler use is recorded.
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 approval process is being followed and current consents were in place for the use of restraint. Bedrails, lap belts and brief belts have been approved The restraint approval group comprises the restraint coordinator/FM, the unit team leader, the resident's family member/EPOA and the resident's GP for final sign off. Members of the group interviewed confirmed they 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 that there were clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed. Evidence of family/whānau/EPOA 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.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint were documented and included all requirements of the standard. An RN/ team leader undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/ EPOA and the GP. The FM interviewed (who was the interim restraint coordinator) 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.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The use of restraints is actively minimised, and the FM/restraint coordinator and other staff described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats, low beds, perimeter guards, increased staff supervision and regular toileting as identified in a continence assessment regime).

		When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. A restraint register is maintained, updated every month, and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record. Staff training records showed that education and updates about restraint minimisation has occurred this year. New staff are oriented to the organisation's policy and procedures and other related topics, such as positively supporting 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.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' files showed that the individual use of restraints is reviewed every three months and evaluated during six monthly care plan and interRAI reviews. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure were followed and documentation completed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint committee undertakes a monthly quality review of all restraint use which includes all the requirements of this Standard. The most recent review occurred in August 2021. Individual use of restraint use is reported to monthly health and safety/quality and staff meetings. Minutes of the monthly restraint quality review meeting confirmed that the review included 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. Any changes to policies, guidelines, education, and processes are implemented if indicated. An audit of restraint is completed as per the schedule.

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.

No data to display

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 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	The clinical team at Ranfurly recognised a space was needed to support dementia residents when they were transferred from the dementia unit into hospital level care. A place where they are still supported to maintain quality of life and ensure that they are not excluded socially due to behaviours out of their control. The aim was to integrate residents into a routine and to provide an experience or interaction involving sensory activities, supporting emotional and physical health. This also ensured that disruption to other residents was minimised. Although this space was created for dementia residents in mind, it is also used by other residents with similar needs. The diversional therapist and hospital team leader identified a space that provided a social environment and visibility for staff to monitor the needs of the residents. The space was quiet enough to reduce environmental stimuli when required. Staff across all levels of care in the service became involved in the project. Education was provided to staff on challenging behaviours and included using the space to comfort, reduce anxiety, provide one-on-one activities/care,	The clinical team at Ranfurly recognised a space was needed to support dementia residents when they were transferred from the dementia unit into hospital level care. A place where they are still supported to maintain quality of life and ensure that they are not excluded socially due to behaviours out of their control. The space aimed to integrate residents into a routine and to provide an experience or interaction involving sensory activities, supporting emotional and physical health. This also ensured that disruption to other residents was minimised. Although this space was created for dementia residents in mind, it is also use by other residents with similar

		and provide a community for the residents. The layout included joining two tables together, placing comfortable chairs like the layout in the dementia unit. Activities that were familiar to the residents were provided including sensory and sight - ensuring the view to the garden, bird life and bird feeders was visible from the tables. A radio was available, TV-DVDs and extra games/picture books activities set up on the bookshelf, and calming colours and smells with the use of a diffuser, lavender oil, and fresh flowers. Other senses experiences included: Touch – hand creams, fiddle mitts, sensory lap quilts, and wooden puzzles; Taste - if the resident is not coping in the main lounge, meals are served in this area, although others can encourage better food intake and a sense of community; Sound – music, day to day foot traffic of staff, other residents and visitors that engage on their way past. During warmer days, doors to a courtyard are opened, allowing ambient garden sounds to come in. Timeframe for the project was June 2021- August 2021 and continues as it has become so successful. The review process included a range of tools, from progress notes, adverse events, behaviour charts and family, staff and residents' feedback. Behaviour charts, progress notes and adverse events reviewed at clinical meetings by the team leaders and the clinical and quality manager identified a reduction in events related to challenging behaviours. Family feedback was given verbally as families visited. They commented on the positive change in the behaviour of their relative. Resident feedback was verbal and observed. Residents no longer expressed frustration over a behaviour and their understanding improved. Staff feedback given at handovers and during shifts was positive. Success has resulted from this quality initiative to improve residents' quality of life. The residents are supported to maintain healthy social relationships with other residents. This has provided a community within a community atmosphere that supports all residents with a cognitive impairment and residents who require additional support to improve the quality of life and health outcomes. Residents now can foster meaningful relationships with others, where normally they would not have the opportunity. Staff can see the visual impact this has on the residents. Staff are continuing to develop this strategy and implement it into additional areas within the facility. This has had positive outcomes for all those involved - residents, families and staff.	needs. Review has shown the positive benefits including a reduction in challenging behaviours and a positive outlook for all residents, especially those transitioning from the dementia unit into the hospital area.

End of the report.