

# Ranfurly Manor Limited - Ranfurly Residential Care Centre

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## Introduction

This report records the results of a Surveillance 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: 2 August 2017 End date: 3 August 2017

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 134

# 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
	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
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 Manor Ltd operates two privately owned aged care facilities in the Manawatu. The Director also owns Eileen Mary Age Care LTD in central Hawke's Bay. Ranfurly Residential Care Centre is one of these and is based in Fielding.

Ranfurly Residential Care Centre provides rest home, hospital and dementia level care for up to 157 residents. A general manager has oversight of all three facilities, and is based at Ranfurly. The service is managed by a facility manager with a care manager as a direct report. Residents and families spoke positively about the care provided.

This surveillance 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 members, management, staff, contracted allied health providers and general practitioners.

This audit has resulted in one area for improvement, relating to all required supports being included in residents' plans. Improvement has been made in relation to the use of interRAI assessments for all residents at entry and when reassessments are due, as identified at the provider's previous certification 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.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provided residents and families with the information they need to make informed choices and give consent.

A complaints register is maintained with complaints resolved in line with the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights.

## 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.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the owner is regular and effective. An experienced and suitably qualified person manages the facility.

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 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.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff and a designated general practitioner. On call arrangements for support from senior staff are in place. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by two diversional therapists, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards.

## 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.
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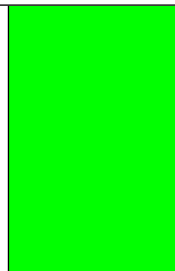
There is a current Code of Compliance for the facility. Ranfurly is a purpose-built facility, appropriate for the needs of its residents. It has been built on one level with fixtures and fittings which promote independence and mobility.

## 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.
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There are policies and procedures to guide the use and minimisation of restraints and enabling equipment. A small number of residents were using enablers during the audit visit, all with their consent. A managed process is in place to oversee and monitor the use of this equipment.

## Infection prevention and control

<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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Aged care specific infection surveillance is undertaken, data is analysed, trended, benchmarked 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	16	0	1	0	0	0
<b>Criteria</b>	0	41	0	1	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints and service feedback policies and form meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission, and is accessible within the facility. Those interviewed knew how to raise a complaint.</p> <p>The facility manager manages all complaints and maintains the complaints register. This was reviewed with both the facility manager and general manager. Since the last onsite audit there has been an increase in the number of recorded complaints. In 2015 six complaints were recorded for the year. In 2016 18 complaints were recorded and to date in 2017 14 complaints are recorded. Review of the register shows that residents and family members are making complaints verbally, in writing, and using the Service Feedback Form. This is a change over time.</p> <p>A random sampling of complaints from 2017 was reviewed. This demonstrated that actions have been taken, through to an agreed resolution, are documented and completed within the required timeframes. Where required, action plans showed follow up and improvements have been made where this was appropriate.</p> <p>There have been no complaints received from the Health and Disability Commissioner, however several complaints have been made through the local district health board (DHB). As well as the random sample, two of the complaints to the DHB were reviewed in detail and in particular follow-up actions which were required by the portfolio manager. Progress is being made to undertake the training and required staff briefings.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required if a</p>

		resident or family member raises a complaint with them.
<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 interviewed during this unannounced surveillance audit described being kept well informed about any changes to their, or their relative's health status. Family confirmed they were advised in a timely manner about any incidents or accidents and the outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Evidence of related training was sighted and confirmed through interview with staff.</p> <p>There are guidelines for staff to access interpreter services. Staff reported this is not currently required as there are no residents who use English as a second language in the facility.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>There is a June 2017- June 2018 business plan which outlines the purpose, values, scope, direction and goals of the organisation. The document describes annual objectives and the associated actions. A sample of monthly management meeting minutes showed adequate information to monitor performance is reported and recorded. This includes occupancy, staffing, emerging issues and risks, and links with a range of other meetings held which monitor operational issues.</p> <p>The service is managed by a facility manager who is a registered nurse (RN) with experience as a care manager and acting facility manager, prior to taking up this role at Ranfurly Residential Care Centre in May 2016. She has completed management training, has a Professional Development and Recognition Programme (PDRP) at Level 3 and a Post-graduate Diploma in Nursing. The facility manager reports to the Ranfurly Manor general manager, who has oversight of the three facilities which make up the Ranfurly Manor group. The GM is also a RN who maintains her practising certificate and has experience managing aged care facilities.</p> <p>Responsibilities and accountabilities are defined in job descriptions for both the general and facility manager roles. At interview, both managers demonstrated their knowledge of the sector, regulatory and reporting requirements and the contracts held by the facility.</p> <p>The service holds contracts with their DHB, the Ministry of Health and the Accident Compensation Corporation (ACC) for Young People with Disabilities (three), respite, long term chronic health conditions, day care, palliative care, health recovery beds, ACC serious injury clients).</p> <p>There are 157 available beds across Ranfurly. On the days of audit 134 residents were receiving services. There are 53 apartments with a total of 63 beds (there are 10 double apartments and 43 single) which residents enter with an occupational right agreement. Residents are able to receive rest home or hospital level care in these apartments, although not all apartment residents may be assessed as requiring care at any one time. On the day of the audit 44</p>

		<p>apartment residents were receiving rest home level care. There are a total of 74 dual use beds. On the day of audit 70 residents were receiving hospital level care. The dementia unit currently accommodates a maximum of 20 residents. On the day of audit 20 residents were in the unit.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></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 business has a planned quality and risk system that is based on continuous quality improvement principles. This includes the control and regular review of policies and procedures, reporting and management of adverse events including complaints and clinical incidents, regular meetings with residents and a process for gaining feedback on services.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and objectives in the business plan. Information is reported and discussed at a range of regular meetings, including the management team meeting, quality and health and safety committees, team leaders' meetings, residents' meetings and staff meetings. This included internal audits. Clinical audits are overseen by the care manager, including care plan monitoring and interRAI assessment completion. All other audits are overseen by the RN clinical and quality support, ranging from cleaning and laundry services, fire and health and safety checklists. Staff reported their involvement in the range of meetings appropriate to their role and quality and risk management activities. When needed, relevant corrective actions are developed and implemented to address any shortfalls. Examples were seen along with appropriate ongoing monitoring.</p> <p>Resident and family satisfaction is monitored regularly through a formal annual survey and the regular meetings. A range of meetings were reviewed and survey results from the 2017 survey were reviewed. The most recent survey showed an overall high level of satisfaction from residents and family members who responded to the survey. Meeting minutes record individuals raising issues during meetings and these being tracked and reported back on through the meeting minutes. Issues reported in the most recent meeting prior to the audit included a lack of face clothes, more van outings and one person's perception that their family were not able to visit frequently. The minutes record appropriate responses during the meeting and corrective actions recorded on the minutes document to continue to address these issues. Management meeting minutes record discussion of the ongoing issues after the residents' meeting.</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 general manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Business risks are identified in the business plan and monitored through the management reporting processes. The general manager and facility manager are both 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 reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an AIM (accident/incident/medication event) form. A sample of AIM forms reviewed showed these were fully completed, all were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to individual staff teams, the quality and health and safety committees, the qualified nurses meeting, the general staff meeting and the management team meeting. Depending on the meeting, different information is discussed and actions taken, appropriate to the meeting.</p> <p>The general manager and facility manager both described essential notification reporting requirements, including for pressure injuries. An example of a pressure injury notification was seen during the audit. (This had been reported several months prior to this audit.) They advised there have been no notifications of significant events made to the Ministry of Health, other than pressure injury notifications, since the previous audit.</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>FA</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, practising certificates and/or professional registration, where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. All personnel files reviewed were well organised and current.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that their orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation, a performance review after a three-month period and annually thereafter.</p> <p>Continuing education is planned on a biennial basis and includes 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 District Health Board. A staff member is the internal assessor for the programme. Staff working in the dementia care area have either completed, or are enrolled in, the required education.</p> <p>There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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 process for staffing the facility with a mix of skilled staff members appropriate to the needs of residents, 24 hours a day, seven days a week. Staffing levels are adjusted to reflect the changing needs of residents over time. The roster reflected the availability of on call staff, qualified nurses and trained staff to meet contractual requirements.</p> <p>The facility manager was interviewed during the audit and a range of other staff members. The facility manager demonstrated a sound understanding of rostering requirements for a facility the size of Ranfurly. There is a process to monitor shift changes during a rostered week.</p> <p>Staff reporting that good access to advice is available when needed and that there are adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any absences. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage in the hospital.</p>
<p>Standard 1.3.12: 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 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. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. 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 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 review was consistently recorded on the medicine chart.</p> <p>There were four residents self-administering inhalers at the time of audit. Appropriate processes were in place to</p>

		<p>ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the care manager and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors and compliance with this process was verified.</p> <p>Standing orders are not used.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a cook, qualified chef and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has just been reviewed by a qualified dietitian (July 2017). Recommendations made included a reduction in the use of cream and an increase in protein, and are in the process of being 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 control plan and registration issued by Manawatu District Council (19/1/2017). 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 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. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction and dissatisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Evidence was sighted of ongoing initiatives being implemented to address residents' dissatisfactions and improvements in the level of satisfaction was verified.</p> <p>Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There was sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p>	FA	<p>Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity and nutritional screening, 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' files reviewed have current interRAI assessments completed by one of 11 trained interRAI assessors on site.</p>

gathered and recorded in a timely manner.		
<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>	PA Low	<p>Documentation, observations and interviews verified the provision of care provided to eight of twelve residents was consistent with their needs, goals and the plan of care, however the documentation in four of the files did not fully identify all aspects of the care required. Interviews verified this was a documentation issue, and the required care was verified as being provided.</p> <p>Interventions describing the required management of residents in the secure unit was comprehensive. Interventions around wound care, infections and continence issues was comprehensive with detailed management programmes to ensure each resident's needs were met and residents comfort maintained. The management of continence concerns throughout the service included a comprehensive continence assessment and a documented management plan that also identified product use. Any requirements for extra continence products, beyond that identified in the assessment process, was available and accessible at all times. Where additional products was frequently required, a reassessment was undertaken, and a review of the plan undertaken, as verified by interviews, documentation and observation.</p> <p>The three GPs interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a satisfactory standard. Care staff stated that care at times was not well documented. All care requirements or changes were updated in verbal handovers and documented on a handover sheet. 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>	FA	<p>The activities programme is provided by two diversional therapists and runs over six of the seven days each week.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as residents needs change and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included fortnightly visits by Plunket mothers and their babies, kindergarten visits three to four times a term, visits by the kapa haka group, the local school putting on a barbeque for the residents each year on daffodil day and attendance by entertainers each week. The activities programme is discussed at the minuted residents' and family meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed</p>

		<p>they find the programme meets their needs. Interviews with younger residents verified they are enabled to participate in activities going on in the community, and rarely engage in the activities provided in-house for other residents.</p> <p>Activities for residents from the secure dementia unit are specific to their needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This has resulted in a reduction of disruptive behaviour.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<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.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans were consistently reviewed and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound, continence, behaviour and infection management plans are evaluated for effectiveness of the management strategies put in place, with changes implemented where required. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There is a current Certificate of Public Use / Code of Compliance for the facility. Regular building and equipment checks associated with the facility were up to date and occur as scheduled. Evidence of these was reviewed during the audit along with the facility's own monitoring procedures.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this and management is documented in the residents' clinical records and on an infection reporting form. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The infection control nurse reviews all reported infections. Monthly surveillance data is collated, recorded in the resident management system and analysed to identify any trends, possible causative factors and required actions. Results of the</p>



<p>objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>surveillance programme are shared with staff via team meetings, quality meetings, staff meetings and at resident handovers, as was confirmed in meeting minutes sighted and interviews with staff.</p> <p>Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported through all levels of the organisation.</p> <p>A summary report for a recent norovirus 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: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<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 RN clinical and quality support provides support and oversight for enabler and restraint management in the facility. She has been the restraint coordinator and was interviewed due to the absence of the person currently holding this role. She demonstrated a sound understanding of the organisation's policies, procedures and practice.</p> <p>On the day of audit, three residents were using enablers. All were the least restrictive equipment option and were being used voluntarily at their own request. A similar process is followed for the use of enablers as is used for restraints. Files for these three residents were reviewed, as well as the restraint and enabler register. Records were consistent. Interviews with the residents using enablers who were available, confirmed that they were satisfied with the support provided.</p> <p>Other care staff members interviewed were able to describe the voluntary use of enablers and confirmed that only approved enablers are used at the facility.</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)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Documentation, interviews and observation verified eight of twelve lifestyle care plans reviewed reflected the residents' required support needs, however there were noticeable gaps in four of twelve care plans around the documented interventions required to meet the residents' needs. This specifically related to residents with increased frailty and nutritional deficits requiring to be fed at meal times, residents identified at risk of developing PIs and residents noted to have lost weight in the past month.</p> <p>There is minimal documentation in the care plan to identify the actions required to address these areas of residents' need. Interviews and observation verified the required support is being provided. Care staff verbalised documentation in care plans is not always consistent with the care the resident requires. This gap in documentation has recently been identified by the service's internal audit programme and evidence was sighted of processes being implemented to address these deficits, and therefore minimise the risk.</p>	Documentation at times does not always describe the required support to meet the residents' identified needs following assessment.	<p>Documentation describes the required support needed to meet residents' assessed needs.</p> <p>180 days</p>

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## 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.

No data to display
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End of the report.