

Ranfurly Manor Limited - Nelson Residential Care Centre

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:	Nelson Residential Care Centre
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 October 2019 End date: 29 October 2019
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:	40

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
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

Nelson Residential Care Centre provides rest home level care for up to 49 residents. The service is operated by Ranfurly Manor Limited and is managed by a facility manager.

Residents and families were complementary of the standard of care provided.

This unannounced 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, families, facility manager, staff, and a general practitioner.

A provisional audit was undertaken in September 2018 prior to a potential change of ownership, however a change of ownership did not eventuate.

The area requiring improvement from the previous certification audit relating to medicine management is closed. Improvements required from the provisional audit undertaken in September 2018 relating to corrective action plans, rosters and activities are closed.

An area requiring improvement from this audit relates to aspects of the management of controlled drugs and expiry and dating of eyedrops.

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

The facility manager is responsible for the management of complaints and a complaints register is maintained. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

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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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 Nelson 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.

The facility is managed by an experienced and suitably qualified manager, who is a registered nurse. The facility manager is supported by the general manager, two registered nurses and senior staff from the other local facility within the group.

There is an internal audit programme in place. Adverse events are documented on accident/incident forms. Corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Staff and resident 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. Human resources processes are 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. The facility manager is on call after hours.

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 medium or high risk and/or unattained and of low risk.
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Residents' of Nelson Residential Care Centre have their needs assessed by the multidisciplinary team on admission within the required timeframes. 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.

The planned activity programme is overseen by a diversional therapist and 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 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. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen is well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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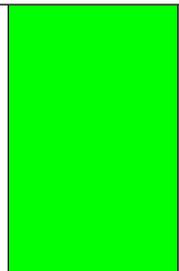
A current building warrant of fitness is displayed. There have been no structural alterations since the previous audit.

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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The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were no residents using a restraint or enabler at the time of audit.

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, 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)
Standards	0	15	0	0	1	0	0
Criteria	0	38	0	0	1	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The information is provided to residents and families on admission and complaints information and forms are available at the main entrance.</p> <p>There have been five complaints since the previous audit and these have been entered into the complaints register. Complaint documentation was reviewed and actions taken were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible.</p> <p>The FM is responsible for complaint management and follow-up. Staff interviewed confirmed a sound understanding of the complaints process and what actions are required.</p> <p>The FM reported there have been no complaint investigations by external agencies since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	FA	<p>Residents and families stated they are kept well informed about any changes to their own or their relative's status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the local DHB if required. The facility manager(FM) advised there are currently no residents who require an interpreter.</p> <p>Observation by the auditors evidenced effective communication and interaction between staff, residents and families. Residents and families confirmed this.</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>	<p>FA</p>	<p>Nelson Residential Care Centre is one of a group of facilities governed by Ranfurly Manor Limited. The facilities are overseen by a general manager(GM). The business plan 2019-2020 outlines the vision, philosophy, principles of care, service goals, expected measures, results and corporate commitment of the organisation. The FM provides monthly management reports to the GM and reported they are in contact with the GM daily. Reports reviewed, include but not limited to staffing, occupancy, interRAI assessments, quality data, complaints, education financial performance, emerging risks and issues. The GM provides regular verbal reporting to the owner who is the director of the business and holds regular governance meetings. Monthly senior management meetings are held with senior staff from both the facility and the other local facility within the group.</p> <p>Nelson Residential Care Centre is managed by a FM who is a registered nurse and has been in the role for two years. Prior to this position, the FM worked as a clinical manager for another organisation. The FM is supported by the GM, RNs and senior management staff from the sister facility nearby. Responsibilities and accountabilities are defined in a job description and an individual employment agreement. The FM has good knowledge of the sector, regulatory and reporting requirements and attends the forums provided by the local DHB.</p> <p>Nelson Residential Care Centre holds contracts with the local DHB for rest home level care (33 residents), complementary/respite care (three residents under the age of 65 years and one resident over the age of 65 years) and long term chronic (three residents under the age of 65 years).</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p>	<p>FA</p>	<p>A quality plan 2019 includes a purpose, scope, overview and outcomes which guides the quality programme. This includes management of incidents and complaints, audit activities, resident and family satisfaction surveys, monitoring of outcomes, clinical incidents including skin tears, infections, medication errors, falls and restraint use.</p> <p>Quality data is collected, collated, analysed including audits, incidents/accidents, surveys and clinical indicators and entered into an electronic spread sheet. Corrective actions are developed and implemented with evidence of close out using the organisations systems. The requirement from the provisional audit is closed. Staff meetings include quality, health and safety, infection control and restraint and residents' meetings are held</p>

<p>continuous quality improvement principles.</p>		<p>regularly. Meeting minutes evidenced reporting back to staff of corrective actions and trends as a result of analysing quality data. Staff interviewed confirmed they discuss quality data and what corrective actions are required.</p> <p>The satisfaction surveys for 2019 have been completed and the FM reported they are currently being collated. The FM reported they have looked at the individual surveys and they evidenced satisfaction with the service provided.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies are reviewed at least two yearly and are current. Obsolete policies are archived electronically. Staff are notified via the staff meetings of reviewed updated/new policies. The FM stated new/reviewed policies are provided in hard copy for staff to read, in the nurses' station. Discussion is held during staff meetings. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for service delivery.</p> <p>A risk management guide includes a matrix and hazard/risk register and includes risks associated with clinical, human resources, legislative compliance, contractual and environmental risk. The hazard/risk register includes actual and potential hazards and the actions put in place to minimise or eliminate each hazard. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed they understood and implemented documented hazard identification processes.</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>Adverse, unplanned or untoward events are documented by staff on incident/accident forms. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>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.</p> <p>Policy and procedures comply with essential notification reporting. The FM demonstrated a sound understanding of 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 FM reported there has been one section 31 notification to HealthCERT since the previous audit. Documentation reviewed confirmed this.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	<p>FA</p>	<p>Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>The orientation booklet is partly generic for all staff and partly role specific with different timeframes for RNs and care staff to complete. Staff performance is reviewed at the end of the period and annually thereafter. Orientation for staff covers all essential components of the service provided.</p> <p>In-service education is provided for staff at least monthly. External speakers provide some sessions and staff attended other external education. Individual records of education and attendance are held on staff files and in the education folder. Competencies were current including medication management. The FM and another RN are interRAI trained and have current competencies. There is at least one staff member on each shift with a current first aid certificate.</p> <p>A New Zealand Qualification Authority education programme (Careerforce) is available for staff to complete and they are encouraged to do so. A staff member is the Careerforce assessor. Two care staff have attained level two, four have attained level three with four currently completing the programme and four have attained level four with two staff members currently completing the programme.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>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.</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 rationale for determining staffing levels and skill mix to provide safe service delivery.</p> <p>The number of residents residing in the facility has increased since the previous audit and staff hours have slowly been increased as a result. A new roster is to be introduced in two weeks especially reflecting the increase in RN hours. The FM and GM reported the rosters are reviewed continuously and dependency levels of residents and the physical environment are considered. Review of the rosters showed who has a current first aid certificate. Previous rosters reviewed now indicate the actual staff who worked on several days when there was unplanned leave. The requirement from the previous audit is closed.</p> <p>The FM is full time, with an RN from the other facility within the group nearby currently works one day a week, with hours to increase to two and a half days. Another RN recently employed full time is a new graduate and is currently being orientated. The RN is rostered on the afternoon shift Sunday to Thursdays. Caregivers are employed to cover the three shifts and additional hours are available if the acuity levels of residents increase. The FM reported there is a casual pool of care givers and an EN if required. A diversional therapist is employed Monday to Friday for three hours each day. The GM reported this area has also been reviewed with a view to employing another activities person.</p> <p>Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and families reported they are happy with the staffing levels and there are enough staff on duty</p>

		that provides them or their relative with an adequate standard of care. Observations during the audit confirmed adequate staff cover is provided.
<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>PA Moderate</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, except for documentation around controlled drugs and the use of eyedrops within use by dates.</p> <p>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.</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. Apart from a residents eyedrops, all medications sighted were within current use by dates. Clinical pharmacist input is provided on request. A corrective action identified at the previous certification audit, found inconsistencies between the warfarin dose authorised on the electronic prescription and the documented dose required on the paperwork from the laboratory. A review of records and administration records of two residents on warfarin, verified accuracy between the dose authorised, the paperwork from the laboratory and the dose administered. This corrective action has been addressed.</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 of those drugs being recorded. The controlled drug register, however, did not record fully all the controlled drugs on site, and this requires attention.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's 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 is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the FM/RN 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>	<p>FA</p>	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in August 2019. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place and registered with the Manawatu District Council. A verification audit of the food control plan was undertaken in February 2019, with the food control plan verified as compliant and registered for 18 months</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has a diploma in gourmet cooking and in nutrition. Kitchen assistant's complete relevant food handling training, under the direction and oversight of the cook.</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. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents at Nelson Residential Care Centre was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. 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</p>	<p>FA</p>	<p>The activities programme is provided by a trained diversional therapist.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. A previous corrective action identified at a previous provisional audit, identified there</p>

<p>the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>were no documented activity plans for each individual that addressed the specific individualised activities required to meet the recreational needs of the resident. This corrective action from the previous audit has been addressed, with all files reviewed have individualised recreation plans in place which identified the specific activities the resident requires to meet their needs. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly 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 include twice weekly outings, attendance at several community events, dog therapy, outings to the men's shed and library, visiting entertainers, quiz sessions and daily news updates. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Residents and family members of residents confirmed they find the programme meets their needs.</p> <p>Residents under 65, have an area in the facility where they can meet as a group. The present activities programme enables residents under 65 years to access community activities, events or interest groups as requested. A recent survey was conducted of residents under 65 years to identify what activities they would find of interest, which identified they would like more movies. A plan is in place to address this request.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</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. Examples of short-term care plans were consistently reviewed for infections, pain, weight loss and progress 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 dressing was changed. 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</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed that expired on the 28 February 3020. There have been no structural alterations undertaken since the previous audit.</p>

environment and facilities that are fit for their purpose.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance of infections at Nelson Residential Care Centre 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 is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The FM/RN is the infection control nurse and reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers. The restraint coordinator is an FM and demonstrated an understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>The facility maintains a restraint free environment and there were no residents using an enabler. Residents are monitored closely and equipment is in use so that restraints are not required. Regular training occurs for staff on restraint minimisation and safe practice and staff interviewed demonstrated good knowledge.</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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration and the controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries of those drugs being recorded. The controlled drug register did not, however, include a record of two bottles of a liquid medication that was in the cupboard and charted for a resident use ‘as required’, nor was the drug recorded in the index of the register. The old register records the drug, and the minimal amount left in the bottle. The documentation for this was not transferred to the new controlled drug register. A new bottle of the medicine was not signed in, when supplied by the pharmacy. The new bottle remains unopened and the old bottles contents are consistent with the last record in the old register.</p> <p>A resident’s eyedrops have not been discarded as per the discard date recorded on the container. A new set of eyedrops have been opened, however no record of an opening date or discard by date is recorded.</p>	<p>The documentation in the controlled drug register does not reflect accurately the controlled drugs onsite and does not meet legislative or safe medication management guidelines.</p> <p>Eyedrops</p>	<p>Provide evidence that controlled drugs are managed as per legislative and safe medicine management guidelines. Provide evidence a process is in place to ensure eyedrops are managed within their use by dates.</p>

			have not been discarded as per their use by date.	30 days
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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, 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

End of the report.