

# 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:

<b>Legal entity:</b>	Ranfurly Manor Limited
<b>Premises audited:</b>	Ranfurly Residential Care Centre
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 17 March 2020 End date: 18 March 2020
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	131

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

Indicator	Description	Definition
	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 161 residents. The facility is owned by Ranfurly Manor Limited and is managed by a facility manager with support from a clinical manager and general manager. Residents and families spoke positively about the care provided.

This unannounced surveillance audit was conducted against the Health and Disability Service Standards and the service's contract with the District Health Board. The audit process included review of policies and procedures, review of patients' and staff files, observations and interviews with residents, family/whānau, management, staff, general practitioners and a nurse practitioner.

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

Improvements required from the previous provisional audit related to position descriptions for the restraint and infection control coordinators, identifying what staff are on duty with a current first aid certificate and documentation relating to residents' recreational needs are closed.

There were 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.



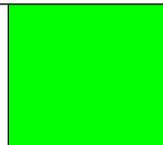
Standards applicable to this service fully attained.

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 complaints received by the Health and Disability Commissioner's office 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.

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 owner.

The facility is managed by a facility manager who has been in the role for two years. The facility manager is supported by a clinical manager and a general manager. The clinical manager is responsible for the oversight of the clinical service in the facility.

Quality and risk management systems are followed. There is an internal audit programme. Adverse events are documented. Various staff, quality/health and safety and residents' meetings are held on a regular basis.

Policies and procedures on human resources management were in place and processes followed. An in-service education programme is provided, and staff performance is monitored.

The hazard register evidenced review and updating of risks and the addition of new risks.

The documented rationale for determining staffing levels and skill mixes is based on best practice. Registered nurses are always rostered on duty. The senior management team are 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.		Standards applicable to this service fully attained.
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Residents of Ranfurly Care Centre have their needs assessed by the multidisciplinary team on admission within the required timeframes. Verbal shift handovers and handover reports guide continuity of care.

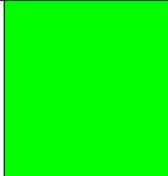
Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes were identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided was of a high standard.

The planned activity programme is overseen by three activities co-ordinators. The activities programme provides residents with a range of individual and group activities. Residents are enabled to maintain 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. Policies guide food services delivery. This is supported by staff with food safety qualifications. The kitchen was 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 code compliance certificate is displayed at the front entrance. 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 residents using restraints and enablers 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, 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)
Standards	0	16	0	0	0	0	0
Criteria	0	39	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information is provided to residents and families on admission and there was complaints information available at the main entrance. Eighteen complaints received in 2019 and two in 2020, to date, have been entered into the complaints register. Three complaints were reviewed and actions taken were documented and completed within the timeframes specified in the Code. Action plans reviewed evidenced any required follow up and improvements have been made where possible.</p> <p>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.</p> <p>There have been no complaint investigations by external agencies since the previous audit. The FM and general manager (GM) reported they advised the local DHB of a complaint received in May 2019 concerning the care of a resident. The facility investigated the concerns raised and the FM advised they kept the DHB informed as requested. Review of documentation evidenced the complaint was managed well.</p>
<p>Standard 1.1.9: Communication Service providers</p>	FA	<p>Residents and families interviewed stated they were kept well informed about any changes to their/their relative's status and outcomes of regular and any urgent medical reviews. This was supported in the residents' files reviewed. Staff understood the principles of open disclosure, which is supported by policy and procedures that</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>meet the requirements of the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Interpreter services can be accessed when required. The facility manager also advised residents' family members can act as interpreters, where appropriate.</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>Ranfurly Manor Limited employs a general manager who has oversight of the facilities within the group. The business plan includes a vision, philosophy, principles of care, service goals and corporate commitment. The business plan is reviewed annually.</p> <p>The GM provides weekly reports to the owner prior to the senior management meetings. The reports are a summary of all activities undertaken in the facility including but not limited to quality, infection control, education, occupancy and staffing. Review of the reports and interview of the GM confirmed this. The GM and owner hold verbal conversations at least daily and discuss a variety of activities relating to provision of services at Ranfurly.</p> <p>The facility is managed by an FM who is an RN and has been in the position since February 2018. Prior to this role they were the FM at a sister facility nearby. The FM attended a business and leadership conference in 2020 and is enrolled to complete level five diploma in business.</p> <p>The management of clinical services is the responsibility of the CM who has been in their role since February 2018. Prior to this the CM was the team leader/RN in the dementia unit. The annual practising certificate for the CM was current. There was evidence in the CM's file of attending forums and conferences to keep up to date.</p> <p>Ranfurly Residential Care Centre has contracts with the local DHB, MoH and ACC. On the first day of the audit, 131 residents were receiving services. Aged related residential care contract-115 residents (49 hospital level including 10 residents in the care suites under an occupation rights agreement, 47 rest home level including 30 residents in the care suites under an occupational rights agreement and 19 dementia level care). Residential-non aged contract - 3 x young physically disabled (2 RH and 1 Hosp level) and 3 under the age of 65 years with various health issues - including 1 Hospital level under an occupational rights agreement, 1 respite and 1 RH). Complementary care Services contract-respite - five residents. Hospital recovery – 2 x hospital level residents, chronic medical illness-palliative care x 1 hospital level resident over the age of 65 years and ACC individual contracts, 2 residents (1 x hospital level and 1 x dementia level).</p> <p>All beds have been approved as dual purpose apart from the beds in the dementia unit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an</p>	<p>FA</p>	<p>The quality plan has a purpose, scope, overview, quality targets and outcomes. 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, health</p>

<p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>care assistants and other staff meetings are held regularly and evidenced good reporting of clinical indicators, any trends and discussions around corrective actions. Meeting minutes reviewed were comprehensive with names of people responsible for any corrective actions, timeframes for completion and sign off. Any unfinished business is brought forward to the following meeting.</p> <p>The audit programme for 2019 and 2020 and completed audits were reviewed. Resident and family surveys for 2019 evidenced satisfaction with the service provided, with increased satisfaction compared to the previous year, especially in the areas of care, activities and the food service. Interviews of residents and families confirmed this.</p> <p>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 have recently been made available to staff.</p> <p>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 via email and are encouraged to make comments while documents are in draft. Obsolete documents are archived electronically, and hard copies are put into a secure bin for destruction.</p> <p>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.</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, unplanned or untoward events on hardcopy forms. The CM reviews all completed forms with overview from the GM. Corrective actions are developed and implemented. After a month the forms are placed back into the residents' files. 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 condition. Families interviewed confirmed they were confident of being advised in a timely manner, as need be, following any adverse event or change in their relative's condition.</p> <p>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 confirmed this. Policy and procedures comply with essential notification reporting. The FM advised there has been one essential notifications made to an external agency 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>Policies and procedures relating to human resources management are in place. Staff files included job descriptions which outlined accountability, responsibilities and authority, employment agreements, references, completed orientation and police vetting. All files reviewed included position descriptions including the NM, restraint co-ordinator and the infection control coordinator.</p> <p>An orientation programme is provided. New health care assistants (HCAs) are supported by a senior HCA who works alongside them as an initial 'buddy' and undertakes reviews of the HCA's progress. The FM and CM are responsible for the orientation of new RNs. Orientation for staff covers all essential components of the service provided.</p> <p>The education programme is a strength of Ranfurly. The CM and the team leader/RN from the dementia unit manage the programme. In-service education is provided for staff monthly where one week is dedicated to a topic and is repeated so that all staff can attend. Documentation and interview of the CM and team leader evidenced a sound structure is in place relating to attending sessions. Specific topics relating to residents' health status are discussed at handover and during staff meetings. External educators take sessions and RNs attend sessions at the local DHB. On-line learning is also encouraged. Competencies were current including for medication management and restraint. Of the 21 RNs, eight are interRAI trained, including the CM, 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. Two RNs are the assessors for the facility and HCAs have attained level two and three, with 10 attaining level four. The HCAs working in the dementia unit have completed the dementia modules. All staff have completed at least eight hours of ongoing training annually.</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 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 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.</p> <p>Observations and review of rosters confirmed adequate staff cover is provided, with staff replaced in any unplanned absence. The FM and apartment coordinator 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 pool of casual staff as well to</p>

		<p>call on. The senior managers are experienced RNs. Five of the 21 RNs working on the floor are new graduates and the remaining 16 RNs all have prior aged care experience ranging from three to 30 years.</p> <p>The apartment coordinator 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.</p> <p>A new initiative relating to a mentoring programme for new graduate RNs has been developed and is about to be implemented to help support new RNs. This includes group and one to one support provided by the FM and CM who are also experienced RNs.</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 was 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 were 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 an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs were stored securely in accordance with requirements. Controlled drugs were 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 electronic medicine chart.</p> <p>There was one resident who partially self-administers medication at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and clinical manager (CM) 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>

		Standing orders are not used.
<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 and was in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in August 2019. Recommendations made at that time have been implemented.</p> <p>A food control plan was in place and registered with the Manawatu District Council. A verification audit of the food control plan was undertaken in February 2019 and resulted in an eighteen-month verification. The next audit is due July 2020.</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 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. Special equipment, to meet resident's nutritional needs, was available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. The recent satisfaction survey evidenced an improvement in resident's satisfaction with meals over the past year. 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 were enough staff on duty in the dining rooms at mealtimes to ensure appropriate assistance was available to residents as needed.</p> <p>Residents in the secure unit have access to food items at any time of the day or night.</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>	FA	<p>Documentation, observations and interviews verified the provision of care to residents of Ranfurly 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 were followed, and care was 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 levels of care provided and in accordance with the residents' needs.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by three activities co-ordinators. The programme is overseen by a qualified diversional therapist.</p> <p>A previous corrective action request identified there was no documented activities plan in place for residents that identified the specific individualised activities required to meet residents' holistic needs, nor was there a twenty-four-hour activity plan in place for residents in the secure unit. This has been addressed. All residents' files reviewed had individualised activity plans in place. Additionally, the files of the residents in the secure unit have a twenty-four-hour activity plan.</p> <p>A social assessment and history are 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 regularly and as part of the formal three/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 included normal community activities. Individual, group activities and regular events are offered. Examples included weekly van outings, church services, visiting entertainers, quiz sessions, craft sessions, baking sessions, bowls and daily news updates. The activities programme is discussed at the residents' meetings and minutes indicated residents' input is sought and responded to. A recent resident and family satisfaction surveys demonstrated improved satisfaction with the activities programme being provided at Ranfurly. Feedback from residents and their family members was used to improve the range of activities offered. Residents and family members of resident confirmed they find the programme meets their needs.</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>Residents' care at Ranfurly 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 were sighted of short-term care plans being consistently reviewed for infections, pain and weight loss. Progress was evaluated as clinically indicated and according to the degree of risk noted. Wound management plans were evaluated each time the dressing was changed. Behaviour management strategies were evaluated every time there was an episode of a behaviour that challenges. Residents and families/whānau members of residents 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>	<p>FA</p>	<p>A current code compliance certificate was displayed at the main entrance that expires on the 20 August 2020. The FM reported the local authority required the fire cell divisions in the ceiling be made thicker. The work was completed in 2019. The FM stated the work has been inspected and a building warrant of fitness will be issued prior to the code compliance certificate expiring.</p>
<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>	<p>FA</p>	<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 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 infection control coordinator (ICC) 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 discussed and reported to the CM and shared with all staff via quality, management, health and safety, staff meetings and at staff handovers. Surveillance data is stored in the organisation's infection control manual. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p> <p>A Norovirus outbreak in May 2019 saw eighteen residents and sixteen staff affected. The outbreak was contained promptly and resolved in eight days. The MidCentral District Health Board (MCDHB) and Public Health were informed.</p> <p>Since the last audit a staff member with a notifiable disease was temporarily stood down and appropriate processes implemented to monitor staff and residents under the direction of Public Health, during the 50-day incubation period. No further cases eventuated.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell, not to enter the facility. In addition, in response to the COVID-19 alert, anyone who has been overseas to countries with COVID-19 or in contact with people who have been in countries with COVID-19 are, via signage, advised not to enter the facility. Ongoing education and surveillance of hygiene and handwashing practices were being monitored.</p> <p>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 related responsibilities.</p>
<p>Standard 2.1.1:</p>	<p>FA</p>	<p>The service demonstrated that the use of restraint is actively minimised. Equipment used included sensor mats,</p>

<p>Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>low beds, perimeter guards and alarmed external doors. There were nine residents using restraint and two residents using an enabler during the audit. The FM stated the aim is to have no restraint use in the facility. The FM / restraint coordinator demonstrated good knowledge relating to restraint minimisation. The restraint/enabler register was current. Policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers and knew the difference between the two.</p>
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## Specific results for criterion where corrective actions are required

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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
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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.