# The Ultimate Care Group Limited - Aroha Lifecare

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** The Ultimate Care Group Limited

**Premises audited:** Ultimate Care Aroha

**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: 17 September 2015 End date: 17 September 2015

**Proposed changes to current services (if any):** Please note the name change from Aroha Lifecare to Ultimate Care Aroha.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 43

# 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 |
|  | 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

Ultimate Care Aroha provides rest home, rest home dementia and hospital level care for up to 46 residents. The facility is operated by Ultimate Care Group Limited. Residents and families interviewed spoke positively about the care provided.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the district health board contract. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

The three areas requiring improvement from the previous audit have been addressed.

There are seven improvements required from this audit relating to aspects of quality, staff recruitment, staff education, resident documentation, the activities programmes and aspects of the food service.

## Consumer rights

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Staff demonstrated an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work and caring for residents. Information regarding residents’ rights, access to interpreter services and how to lodge a complaint was available to residents and their families. The complaints register is current and all complaints have been entered. The requirement from the previous audit has been addressed. Staff communicate with residents and family members following any incidents/accidents as appropriate. There has been one external investigation since the previous audit.

## Organisational management

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| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Ultimate Care Group Limited is the governing body and is responsible for the service provided at this facility. A business plan and quality and risk management systems are fully implemented and the documented scope, direction, goals, values, and mission statement were reviewed. Systems are in place for monitoring the service provided including regular weekly reporting by the facility manager to the governing body.

The facility is managed by an experienced and suitably qualified manager. The facility manager is non-clinical and is supported by a clinical services manager/registered nurse. The facility manager and clinical services manager are supported by an operations manager and an audit and compliance manager. The clinical services manager is responsible for oversight of the clinical service in the facility. The facility manager’s file has evidence of an orientation and the facility manager confirmed they have received one. The requirement from the previous audit has been addressed.

There was evidence that quality improvement data has been collected, collated and analysed. There is an internal audit programme in place and internal audits have been completed. Corrective action plans have been developed, however there is minimal evidence of implementation to address areas identified as requiring improvement. Graphs of clinical indicators are available for staff to view along with meeting minutes. Risks have been identified and the hazard register is up to date. Adverse events are documented on accident/incident forms; however, staff are not consistently completing all the sections on the forms.

There are policies and procedures on human resources management. Practising certificates are current for health professionals who require them. Human resources processes are followed apart from not all staff files having reference checks documented.

An in-service education programme for 2015 is documented, however the programme has not been followed and there is minimal evidence of ongoing education provided for staff during 2015. Review of staff records evidenced individual education records are not being maintained. Restraint competencies are not current for clinical staff and care staff interviewed did not know the difference between a restraint and an enabler. Care staff are required to complete the New Zealand Qualifications Authority Unit Standards and those working in the dementia unit have either completed or commenced the dementia modules.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The facility manager and the clinical services manager are on call after hours. Care staff reported there were adequate staff available and that they are able to get through their work. Residents and families reported there are enough staff on duty to provide adequate care.

## Continuum of service delivery

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| 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. |

There is always a registered nurse on duty in the facility. They and the clinical services manager, who is on site weekdays, guide care delivery staff. The clinical services manager is also available on call at all other times. There are well-developed processes in place, such as verbal handovers and communication sheets, to guide continuity of care. Residents’ progress notes are also updated at least twice daily.

Registered nurses are responsible for all aspects of the care planning process. Care plans are individualised, based on a comprehensive and integrated range of clinical information and include input from residents and families. All aspects of the care planning process, including evaluation, are completed within the required timeframes, as are medical admissions and ongoing medical reviews. The development of care planning related to residents receiving insulin therapy is an area for improvement.

The kitchen caters for a range of dietary requirements, and meal services are consistent with the individual food preferences of residents. Residents expressed satisfaction with food services. The main kitchen was well organised and clean and tidy. The dating, covering and discarding of left-over food, the dating and storage of opened packets of frozen foods, the cleaning of the kitchen fridge and the development of kitchen cleaning schedules are areas where improvements are required.

The diversional therapist or the recreation officer are onsite each weekday and every second Saturday and lead the activity programme for residents. This includes outings every second week in the facility van. The development of a formal activities programme for residents in the secure dementia unit, and detailed individualised activities plan, are areas for improvement.

Medications are administered by registered nurses and senior caregivers, all of whom have been assessed as competent in relation to medicines management. Medications are well managed and consistent with legislative and safe practice requirements.

## Safe and appropriate environment

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| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

A current building warrant of fitness is displayed.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Documentation of policies and procedures and interview of the restraint coordinator demonstrated residents are experiencing services that are the least restrictive. There were residents observed using restraint on the day of the audit.

## Infection prevention and control

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| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

Well-developed processes and systems are in place for infection surveillance and for the reporting of and responding to surveillance results. Surveillance data is benchmarked both internally and also with other Ultimate Care Group (UCG) facilities. Systems are in place to ensure staff are aware of surveillance results and that any required action arising from the results is undertaken.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 10 | 0 | 2 | 4 | 0 | 0 |
| **Criteria** | 0 | 32 | 0 | 1 | 6 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The facility manager is responsible for the management of complaints. There are appropriate systems in place to manage the complaints processes. The complaints register is current and evidenced eight written and verbal complaints received for 2015. Documentation showed all complaints have been investigated and complainants provided with responses in a timely manner. The requirement from the previous audit is closed.  There has been one investigation by the DHB since the previous audit relating to the activities programme. Documentation indicated this is now closed. There have been no investigations by the Ministry of Health, Health and Disability Commissioner, Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.  Complaints policies and procedures are compliant with Right 10 of the Code of Health and Disability Services Consumers’ Rights (the Code). Systems are in place that ensures residents and their families are advised on entry to the facility of the complaint processes. Residents and families demonstrated an understanding and awareness of these processes. Resident meetings are held two monthly and residents are able to raise any issues during these meetings. Residents and families interviewed and review of resident meeting minutes confirmed this. Review of the collated resident and family surveys for 2015 evidenced residents and families knew the process for making a complaint.  The complaint process and forms were observed to be readily accessible and displayed. Quality, registered nurse (RN) and staff meeting minutes evidenced reporting of any complaints is an agenda item. Care staff confirmed information was reported to them via their staff meetings. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The service has an open disclosure policy which guides staff around the principles and practice of open disclosure. Education on the Code of Health and Disability Services Consumers’ Rights (the Code of Rights) including communication has been provided this year. Staff confirmed their understanding of open disclosure. Communication with families was documented in the residents’ communication sheets and progress notes. Incident/accident forms do not always evidence whether families were informed when incidents/accidents occurred. (See criterion 1.2.4.3).  Residents and families confirmed communication with staff is open and effective. Care staff were observed communicating effectively with residents during the audit. Residents and family responded positively concerning effective communication from the resident and family surveys recently collated for 2015.  Interpreter services are available to residents via family and external interpreter services if needed. The facility manager advised they have not required interpreter services. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | There are established systems in place which define the scope, direction and goals of the organisation, as well as the monitoring and reporting processes against these systems.  The service philosophy is in an understandable form and is available to residents and their family / representative and other services involved in referring people to the service. The facility manager provides weekly reports electronically to the governing body.  The facility is managed by a facility manager (FM) who is non-clinical and has been in this position for three months. The facility manager has experience working in the health sector including managing other aged care facilities. The facility manager is supported by a clinical services manager who is a registered nurse and was appointed to their current position 10 weeks prior to the audit. The clinical services manager (CSM) has worked in other aged care facilities as a registered nurse and is responsible for oversight of clinical care at Ultimate Care Aroha (Aroha).  Review of the two managers' personal files and interview of the facility manager evidenced they have undertaken education in relevant areas. The facility manager reported they have received an orientation to the position and documentation reviewed in the facility manager’s file confirmed this. The requirement from the previous audit is closed.  Aroha is certified to provide hospital, rest home dementia and rest home level care. On the day of this audit there were 20 hospital level care residents, 10 rest home level care residents and 13 dementia level care residents.  Families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and admission agreements. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | A quality and risk management plan is used to guide the quality programme and includes goals and objectives.  The resident and family satisfaction surveys have been recently collated for 2015 and results indicated that residents and families were satisfied with the services provided. Corrective actions have been developed for areas requiring improvement. The requirement from the previous audit has been addressed.  Completed audits for 2015, clinical indicators and quality improvement data was recorded on various registers and forms both hard copy and electronically. Quality improvement data is being collected, collated, and analysed to identify trends. Corrective actions are developed when necessary, this requirement from the previous audit has been addressed. However, implementation is inconsistent and review of corrective actions was minimal. Corrective actions do not document who is responsible for the action and the timeframe for completion.  The facility manager provides weekly electronic reports to the governing body. Various meetings are held monthly and minutes were reviewed. The facility manager and clinical services manager stated quality data is discussed at the various meetings. There was documented evidence of reporting of various clinical indicators and quality and risk issues in these meeting minutes. Care staff reported that copies of meeting minutes are available for them to review in the staff areas.  Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice and references legislative requirements. Policies and procedures are reviewed by management and are current. Staff confirmed they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for the service delivery.  A health and safety manual is available. There is a hazard reporting system available as well as a hazard register that identifies health and safety risks as well as risks associated with human resources management, legislative compliance, contractual and clinical risks. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Moderate | Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Accident/incident forms are reviewed by the clinical services manager and signed off when completed. Corrective action plans to address areas requiring improvement were documented on accident/incident forms. The RNs undertake assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate.  Staff confirmed they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Staff also confirmed they are completing accident/incident forms for adverse events. However, review of the forms shows not all sections are completed consistently.  The facility manager and the audit and compliance manager stated they have not had to report any essential notifications to the Ministry of Health since the previous audit. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | Written policies and procedures in relation to human resources management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, police vetting and completed orientations. Three of the eight staff files reviewed had no evidence of reference checking prior to employment. Current copies of annual practising certificates were reviewed for the clinical services manager, registered nurses, enrolled nurse and contractors that require them to practice. Performance appraisals are current.  The facility manager is responsible for the in-service education programme. The education programme for 2015 was reviewed. There has been minimal education provided for staff this year and it was difficult to evidence what education had taken place in 2014. All registered nurses have current medication competencies. Current first aid certificates are held for all RNs and other staff who require them. Clinical staff do not have current restraint competencies. Individual staff attendance records, both in staff files and held electronically, are not up to date.  Registered nurses have the required interRAI assessments training and competencies.  Care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules including the dementia modules. Staff are also supported to complete education via external education providers. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. The facility manager and clinical services manager work full time and are on call after hours. The minimum number of care staff on duty is during the night and consists of one registered nurse and three caregivers (one in the dementia unit and two in the rest home/hospital areas).  Care staff reported there are adequate staff available and that they are able to get through their work. Residents and families reported there are enough staff on duty to provide adequate care. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | All aspects of medication management are consistent with safe practice guidelines and legislative requirements.  Medications are supplied to the facility using the robotics system. Evidence was sighted that these packs are checked against the medication chart by a registered nurse on arrival at the facility. A weekly check of all controlled medication is undertaken, with a more in-depth review undertaken six monthly, as sighted in the controlled drugs register. Surplus and expired medication is returned to the pharmacy. The date of first use of eye drops was recorded on those products currently in use. The majority of medication is administered by registered and enrolled nurses, as well as one senior caregiver. Records were sighted that all of these staff had been assessed as competent in medication administration.  No residents were currently self-medicating, although systems are in place to ensure this would be safely managed if required.  All of the medication charts reviewed contained a current photograph of the resident, medications were appropriately prescribed, discontinued medications initialled and dated, three-monthly reviews of medication had been undertaken, and medication administration records were complete. Medication standing orders comply with Ministry of Health guidelines. An observation of a medication round in the hospital/rest home area and a second round in the secure dementia unit confirmed that medications were administered in a safe and appropriate manner. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Moderate | Three experienced cooks are responsible for the provision of food services at the facility. Only one of the cooks has completed the relevant food safety qualifications but the facility manager advised that she is currently exploring options for ensuring the other two staff complete Unit Standards 167 and 168 in the near future.  The four-week menu is supplied by Ultimate Care Group head office, with summer and winter options. Resident’s individual likes/dislikes and special nutritional needs are identified as part of the admission process, and a copy of this is provided to the kitchen where it is then actioned. It is recommended that the service ensures that all dietary profiles are updated at least annually, not just when resident’s needs change significantly. The kitchen caters for a range of nutritional requirements, including diabetic, vegetarian, soft and puree diets. Specialised crockery and cutlery, such as lip plates and feeding cups, are available to promote resident independence. There is a large dining room for rest home/ hospital residents, as well as a separate smaller dining area in the hospital area. The secure dementia unit also has its own large dining area. Residents who do not wish to have meals in the dining room have their meals delivered to them in their own room. Residents are weighed monthly, and the kitchen is updated about residents’ weight gains/losses.  The cook advised that the kitchen monitors resident satisfaction through regular resident meetings, the annual resident survey, from speaking directly to residents in the dining room, and from monitoring the amount of food returned to the kitchen. Residents interviewed during the audit visit stated they enjoyed the meals at the facility, that alternatives were available to them when they did not like what was on the menu, and that servings were generous.  The management of leftover food and kitchen cleaning does not comply with food safety guidelines, with leftover food not dated or not removed from the fridge in a timely manner if not used. The fridge was not maintained in a hygienic manner, and no cleaning schedules were available on the day of the audit visit. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Registered nurses are on duty 24 hours a day, and together with the clinical services manager, they provide support and guidance for care delivery staff. The house doctor visits the facility at least weekly, and more frequently as required. On interview the doctor expressed confidence in the standard of care provided to residents and stated they were advised in a timely manner of any clinically significant changes to a resident’s condition.  A comprehensive range of information is collected as part of the resident assessment process and there was evidence of this information then informing the development of individualised resident care plans. The care plans of four of five residents who were prescribed insulin therapy lacked sufficient detail to guide the safe management of this aspect of their care. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Moderate | The activities programme at Ultimate Care Aroha is led by a qualified diversional therapist who works three days a week and every second Saturday, and a recreation officer who works the remaining two weekdays. Residents’ previous and current interests are assessed on admission and individual activity plans completed within three weeks and reviewed six monthly, as confirmed in resident records. A record is maintained of resident participation in the activities programme, and resident plans were evaluated three monthly.  Copies of the monthly activities programme are distributed to resident and also displayed around the facility. The activities programme for the July-September was reviewed, and was noted to lack variety. Although two of the residents interviewed stated that they enjoyed the available activities, another commented that there was nothing in the activities programme that interested them. There was no evidence of a comprehensive approach to or plan for meeting the activities needs of residents in the secure dementia unit. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All of the care plans reviewed contained evidence of being consistently and systematically reviewed in a timely and detailed manner and updated when care needs changed.  The nursing care plans for hospital-level residents are reviewed three-monthly by registered nurses, with six-monthly evaluations for rest-home residents and those in the secure dementia unit. Evaluations are also completed earlier as clinically indicated. Short term care plans have been used for infections and also for wounds. The service has just introduced a new short-term care plan format to better accommodate other short term events. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed that expires on the 30 April 2016. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection surveillance programme is structured, systematic and appropriate for the size of the service. The infection control coordinator, a registered nurse, explained that each month data is collected on the incidence of a range of infections, including wounds, urinary tract, skin, eye, upper respiratory tract, gastro intestinal, systemic infections and infection outbreaks. This data is then entered in Ultimate Care Group’s electronic infection control management system, analysed and results/trends graphed. Records were sighted of a range of reports generated by the system, which included internal benchmarking of results and benchmarking across other facilities in the organisation.  The infection control coordinator advised that surveillance results are reported to the facility manager. Meetings minutes confirmed that surveillance results are discussed with registered nursing staff monthly and at the monthly health and safety meeting. Surveillance data is also shared with other individual staff as appropriate. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are currently seven residents using restraint and two residents using an enabler. Documentation of restraint minimisation and safe practice policies and procedures, and their implementation demonstrated residents are experiencing services that are the least restrictive. The restraint coordinator reported they are actively reducing restraint use through monthly review of residents using restraint, and the use of low beds, fallout mattresses, and sensor mats.  Ongoing restraint training has not been provided, restraint competencies for clinical staff were not evidenced and care givers interviewed did not know the difference between a restraint and an enabler. (See criterion 1.2.7.5). |

# 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)** |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | Corrective action plans are being developed where there is a deficit identified following audits, incident/accidents, surveys, staff, health and safety and residents’ meetings. However, there is minimal evidence of implementation, who is responsible for the action, and timeframes that the corrective action plans are to be implemented by. | There is minimal evidence of implementation of corrective action plans, including who is responsible, timeframes, and review. | Provide evidence that corrective action plans are implemented and that the plans include the person responsible, the timeframe, and review following the action plan being implemented.  90 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | There was evidence that staff are documenting unplanned or untoward events on incident/accident forms. However, the majority of forms reviewed do not have all the sections completed including who was or who was not notified of the incident or accident. | Incident/accident forms are not being completed as required. | Provide evidence that all sections on the incident/accident forms are completed.  90 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Job descriptions outline accountability, responsibilities and authority, and the skills and knowledge required for each position. Staff files have employment agreements, a code of conduct, police vetting and completed orientations. Three of the eight staff files reviewed have no evidence of reference checks prior to employment. There are current copies of annual practising certificates for the clinical services manager registered nurses, the enrolled nurse and contractors who require them to practice. | Three of the eight staff files reviewed do not have documented reference checks completed. | Provide evidence that all potential employees have reference checks completed prior to employment.  180 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | There has been minimal education provided for staff this year and the programme for 2015 has not been followed. It was difficult to evidence what education had taken place in 2014. Education provided this year has been the Code of Rights, challenging behaviour, chemical safety, and fire safety. All registered nurses have current medication competencies and first aid certificates. Clinical staff do not have current restraint competencies and care staff interviewed did not know the difference between a restraint and an enabler. Individual staff attendance records, both in the staff files and held electronically, are not up to date. | There has been minimal education provided to staff during 2015 and it was difficult to evidence what education had been provided for 2014. Restraint competencies for clinical staff were not evidenced and care staff interviewed did not know the difference between a restraint and an enabler. Individual records of education are not current. | Provide evidence that: (i) education is provided as stated in the education programme; (ii) all clinical staff have current restraint competencies; (iii) staff education records are up to date.  90 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Moderate | The majority of food procured for the facility comes from one supplier and is delivered to the facility in refrigerated vehicles. On inspection, the pantry area was tidy and organised, and there was evidence of stock being dated when it arrived in the facility and of stock rotation. All food items in the pantry area were appropriately stored. Records were sighted of fridge/freezer temperatures being monitored daily.  While left-over food was generally covered in the fridge, five items were not dated. Two items in the main fridge were past their use-by date, a package of cooked meat was partially uncovered, and the fridge itself required cleaning.  Most items in the freezer had been dated on arrival and were within use-by dates, but more than six examples of frozen items were seen which had not being sealed after being opened and/or were undated.  No kitchen cleaning schedules were available on the day of the audit, although the facility manager advised that new cleaning schedules will be introduced shortly. With the exception of one fridge, the kitchen was clean and tidy. | Leftover food stored in the main fridge or freezers was not always dated and/or completely covered. Leftover food was not disposed of in a timely manner. No kitchen cleaning schedules were sighted. One fridge was not maintained in a hygienic manner. | All aspects of food storage comply with current legislation. A detailed cleaning schedule is developed and implemented for the kitchen.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | The service utilises a variety of assessment tools to ensure that resident’s needs are identified, and care plans are developed to guide care provision relevant to those needs. The management of pain in particular was systematic and well documented in the care plans reviewed. Care plans included interventions to manage specific medical conditions, although the management of residents who were insulin-dependent was not well documented. One resident on insulin therapy had no reference to the management of that therapy in their care plan. The sample of care plans was extended to include the four other residents who were insulin-dependent. Although all of their nursing care plans included reference to their diabetic condition in relation to a range of care plan components, such as skin care and nutrition, little was documented to guide care staff in the management of their insulin therapy. Only one of the resident’s care plans included interventions related to the monitoring of blood sugar levels, and the management of hypoglycaemia (low blood sugar). The care plans of three residents in total contained no reference to their insulin therapy, while the remaining resident’s file contained only very brief information. The medication records and blood sugar monitoring documentation for two residents was reviewed, and confirmed that insulin had been administered as charted, and that blood sugar levels had been taken regularly, were within normal limits, and had been documented appropriately. | Five residents are prescribed insulin. The nursing care plans of four of those residents do not contain sufficient detail related to the management of their insulin therapy to safely guide clinical practice. | Nursing care plans are sufficiently detailed to safely guide clinical practice.  90 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Moderate | The interests and activity preferences of residents are assessed as part of the admission process, an activities plan completed within three weeks, and evaluations of progress towards planned goals completed at least six monthly, as confirmed in resident records.  A monthly activities plan is developed and circulated to residents. Activities included in the programme for July, August and September included newspaper reading, quizzes, pet therapy, music therapy, entertainment, crafts, and a weekly happy hour. The programmes for each of these three months was very similar, with the same activities repeated frequently. For instance, bingo has been planned for nine separate occasions in September.  The recreation officer advised that a small number of residents from the secure dementia unit participate in the activities programme run in the rest home/hospital area of the facility. There was scant evidence of activities being planned for or provided to the other residents in the dementia unit. No organised activities were observed in the dementia unit during the onsite audit visit. Two of two residents’ files in the dementia unit included a 24-hour activities ‘wheel’ which contained little information other than the usual activities of daily living. A separate activities plan for each resident also contained little detail of meaningful activities individualised to meet that resident’s needs. When the sample size of residents’ files reviewed was extended to a third file, a similar lack of activities planning was confirmed. | No evidence was sighted of a formal activities programme for residents in the secure dementia unit who did not or could not join in the rest home/hospital activities programme. The individual activities plans for residents in the dementia unit were brief and did not include specific details of a range of activities that residents would find meaningful. The 24-hour activities plans in place for each resident also lacked detail. During the audit visit, no activities were observed in the dementia unit while the auditors were on site. The activities programme for the rest home/hospital residents lacked variety. | A formal activities programme is developed for residents in the secure dementia unit. The activity plans for each individual resident in the unit include specific details of activities meaningful to that resident, and include detail of activities suitable for the 24-hour period. The service reviews the variety of activities planned for rest home/hospital residents and ensures these are meaningful to residents and reflect their identified needs.  90 days |

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

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

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

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

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End of the report.