

The Ultimate Care Group Limited - Mount Victoria 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](#).

The specifics of this audit included:

Legal entity:	The Ultimate Care Group Limited	
Premises audited:	Ultimate Care Mount Victoria	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 17 October 2016	End date: 17 October 2016
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:	44	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Ultimate Care Mount Victoria provides rest home and hospital level care for up to 51 residents. The service is operated by Ultimate Care Group (UCG) and managed by a facility manager supported by a clinical services manager. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contracts with the district health board and the Ministry of Health. The audit process included review of relevant documentation, residents' and staff files, observations and interviews with residents, families, management, staff and a doctor.

This audit has identified areas requiring improvements relating to training, interRAI assessments, medication and kitchen storage. The area identified as requiring improvement at the previous audit has been fully addressed.

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 formal interpreting services if required. The facility manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Ultimate Care Group is the governing body, with a CEO and an executive team who are responsible for the service provided at this facility. A quality and risk management plan is documented and includes the scope, direction, goals, values and mission statement of the organisation. Systems are in place for monitoring the services provided, including regular monthly reporting by the facility manager to the governing body.

The facility is managed by an experienced and suitably qualified manager who is a registered health professional.

A quality and risk management system is in place which includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection control and resident and family satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to both the quality committee and staff meetings, with discussion of trends and follow up where necessary. Meeting minutes, graphs of clinical indicators and benchmarking results are displayed. Adverse events are documented on accident/incident forms and seen as an opportunity for improvement. Corrective action plans are being developed, implemented, monitored and signed off. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated and the hazard register is up to date.

A suite of policies and procedures cover the necessary areas, are current and reviewed regularly.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. A comprehensive orientation and staff training programme has been developed and regular individual performance review is occurring.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. There is a roster of senior staff on call out of hours.

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

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' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff (eg, a podiatrist, physiotherapist and pharmacist) and a designated general practitioner. On call arrangements for support from senior staff are in place. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrate that needs, goals and outcomes

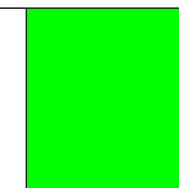
are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

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

Medications are administered by registered nurses, all of whom have been assessed as competent to do so.

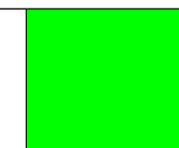
The food service meets the nutritional needs of the residents with special needs catered for. The kitchen was well organised and clean. Residents verified satisfaction with meals.

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 publicly displayed.

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 organisation has implemented policies and procedures that support the minimisation of restraint. All enabler use is voluntary for the safety of residents in response to individual requests. At the time of the audit, ten residents were using enablers to promote and maintain their independence and safety.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Aged care specific infection surveillance is undertaken (analysed, trended, benchmarked) and results are 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	13	0	3	1	0	0
Criteria	0	35	0	4	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. The information is provided to residents on admission in the information folder and there is complaints information and forms available at reception and also at the entrance on level one. Discussion on the complaints process is also a regular agenda item at the two monthly resident meetings.</p> <p>The complaints register reviewed showed that five complaints have been received this year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes specified in the Code. Action plans reviewed show any required follow up and improvements have been made where possible.</p> <p>The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were advised in a timely manner about any incidents or accidents and outcomes of 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</p>

		<p>is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services are able to be accessed via the national interpreter service when required. The facility manager reported this was rarely required due to the use of family members if there were residents for whom English is not their first language.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic and business plans, which are reviewed annually by the national executive team, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives. The facility manager then develops a facility specific plan based on the wider organisational objectives and goals. The facility manager provides monthly reporting against the plan to the regional operations manager and wider senior management team. A sample of reports reviewed shows adequate information to monitor performance is reported including occupancy, staffing, clinical indicators, emerging risks and issues.</p> <p>The service is managed by a manager who is a registered nurse, has significant aged care experience and account management experience. She has been in the role for 18 months. She is suitably skilled and experienced for the role and has responsibilities and accountabilities defined in a job description and individual employment agreement. The facility manager confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through the annual nursing registration requirements. The facility manager is supported by the regional operations manager, who she meets informally on a weekly basis. The national support office team also provide additional support and an organisation wide facility managers meeting is held monthly.</p> <p>The service holds contracts with the DHB and the MoH for aged care, younger persons with a disability (YPD) and respite services. Forty four (44) residents receive services under the contracts (16 rest home level care, 26 hospital level care under the DHB contracts, with two residents under the MoH contract) at the time of audit.</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 continuous quality improvement principles.</p>	FA	<p>The organisation has a quality and risk system that reflects the principles of continuous improvement and is understood by staff. This includes management of incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes and clinical incidents including infections and pressure injuries.</p>

		<p>Terms of reference and meeting minutes reviewed confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs and related information is reported and discussed at the health and safety, quality and risk team meetings and the regular monthly staff meetings. Minutes reviewed include discussion on pressure injuries, restraint, falls, complaints, incidents/events, infections, audit results and activities. An occupational therapist visits regularly to assist with any seating concerns. Staff reported their knowledge and involvement in quality and risk activities through the regular staff meetings. Relevant corrective actions are developed and implemented as necessary and demonstrated a continuous process of quality improvement is occurring. Resident and family surveys are completed annually. The last survey showed all issues identified were documented followed up with relevant corrective action plans implemented.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Staff are updated on new policies or changes to policies through the staff meetings and all are posted on the staff notice boards in the staff room to be signed off when read.</p> <p>The facility manager described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. The risk register shows consistent review and updating of risks, risk plans and the addition of new risks. The organisation is aware of the Health and Safety at Work Act (2015) requirements and has implemented requirements appropriately.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed show these are fully completed, incidents are investigated, action plans developed and actions are followed-up in a timely manner. Adverse event data is collated, analysed and reported to the quality committee and meeting minutes reviewed show discussion in relation to trends, action plans and improvements made.</p> <p>Policy and procedures described essential notification reporting requirements including pressure injuries, health and safety, human resources, infection control, the coroner and the DHB. The facility manager advised there have been no notifications of significant events made to the Ministry of Health since the certification 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>PA Low</p>	<p>National policies and procedures, in line with good employment practice and relevant legislation, guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained.</p> <p>The staff orientation programme includes all necessary components relevant to the role. However incomplete documentation in staff records was unable to provide confirmation of this.</p> <p>Continuing education is planned on an annual basis. Mandatory training requirements are defined and scheduled to occur over the course of the year. Some care staff have either completed or are enrolled for a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Education and training records reviewed, which keep a full attendance schedule and course content, did not reflect that all staff were completing the scheduled training in a timely way. The three interRAI trained RNs are competent to undertake these assessments.</p> <p>Staff reported that the annual performance appraisal process provides an opportunity to discuss individual training needs, supervision requirements and review competencies. Appraisals are completed and were current for all staff.</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 mixes in order to provide safe service delivery. The facility adjusts staffing levels to meet the changing needs of residents, supported by the use of a workload measurement tool. The minimum number of staff is provided during the night shift and consists of three caregivers and a registered nurse. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported adequate staff were available and that they were able to complete the work allocated to them. This was further supported by residents and family interviewed. Observations and review of a two weekly staffing cycle sampled during this audit confirmed adequate staff cover has been provided. The organisation has sufficient staff in its casual pool for short notice roster gaps. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24/7) RN coverage in the hospital.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed.</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>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.</p> <p>The system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of the roles and responsibilities related to each stage of medicine management, however practice observed was not in accordance with safe practice guidelines. 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 registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart.</p> <p>There are no residents who self-administer medications at the time of audit.</p> <p>Medication errors are reported to the clinical manager and recorded on an accident/incident form. The resident and/or the designated representative are</p>

		<p>advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is 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>	PA Low	<p>The food service is provided on site by 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 2016. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines, however some aspects of food storage requires attention. 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, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys, the cook's own daily residents' surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p>
<p>Standard 1.3.6: 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 provided to residents 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 satisfactory. 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 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 two activities personnel, who share the role over the five week days. Activities are provided over the weekends by outside community groups.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal three monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include visits by the local kindergarten, visits from local woman's fellowship groups, church groups and the SPCA. The activities programme is discussed at the residents' meeting and minutes indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed 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>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 three months in conjunction with the three-monthly clinical 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 infection management and progress evaluated as clinically indicated (daily, weekly or fortnightly) 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 environment and facilities that are</p>	<p>FA</p>	<p>A current building warrant of fitness (expires June 30 2017) is publicly displayed.</p>

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 at Ultimate Care Mt Victoria 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 electronic resident management system, infection reporting form and the resident's clinical record. The infection control coordinator 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 regular staff meetings and at staff handovers.</p> <p>There have been no norovirus outbreaks within the past two years.</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 provide guidance on the safe use of both restraints and enablers. The restraint coordinator was on leave on the day of audit, however the clinical services manager confirmed the coordinator provides support and oversight for enabler and restraint management in the facility and has a relevant job description to reflect her role and responsibilities.</p> <p>On the day of audit, ten residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for any restraints. This provides for a robust process which ensures the on-going safety and wellbeing of the resident.</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 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	<p>A comprehensive orientation programme has been developed for the facility. However, while the staff interviewed did confirm they had completed the orientation programme, a number of staff files reviewed had incomplete documentation to support this. Some records did show the programme had been fully completed while others (five of seven records) did not have all sections of the programme completed signed off. A new staff member interviewed was currently in the process of completing the programme.</p>	<p>Not all of the orientation programme had been completed by all staff as required with the relevant sign off processes evident.</p>	<p>Review staff files to ensure they have completed all sections of the orientation programme and these are signed off to reflect this.</p> <p>180 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and</p>	PA Low	<p>A comprehensive annual training programme has been developed for the facility. A review of training records demonstrates that the attendance at these training sessions is inconsistent by a</p>	<p>Records of staff training and ongoing education programmes reviewed do not demonstrate sufficient numbers are attending to</p>	<p>Work with staff to ensure that the training sessions that are provided are attended by as many staff as</p>

effective services to consumers.		number of staff. Two staff had not attended any training so far this year and while several others had only been present for a small number. Overall attendance numbers documented for the training sessions this year have not been as high as would be expected given the actual staff numbers. The clinical services manager does work with individual staff to complete a range of relevant competency assessments and these had been completed by most of the staff.	provide evidence that all care staff are being adequately trained as required.	possible to maintain competency levels. 180 days
Criterion 1.3.12.1 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.	PA Moderate	Observation of a medication round showed that all medications to be administered on the medication round had been signed for prior to the medication round commencing. A prescription request for a resident to be receiving a nutritional supplement twice daily, to address weight loss and potential pressure injuries, had no documentation verifying the supplement had been given. An Interview with the RN verified the supplement was not being given as the resident disliked it. Documentation in the medical notes made no mention of the resident disliking the supplement.	Medications are being signed for prior to the drug being administered. A prescribed nutritional supplement had not been administered, since being prescribed.	A safe medication management system is implemented. 90 days
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	Decanted items in the pantry had no use by dates recorded to determine when they should be used by. An interview with the cook, identified systems are in place and decanted items are used frequently and therefore used well within their use by dates. Stock of these products, were in some cases observed however to be well outside their use by dates.	Decanted items in the pantry had no record of when the items should be used by.	Food items are used within their use by dates 180 days

<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>All files reviewed had interRAI assessments completed within three weeks of admission, however four of the six files reviewed had not had the interRAI assessment reviewed within the last six months. Additional clinical assessments had been completed three monthly and findings of these assessments were used when reviewing the residents care plan.</p>	<p>The residents of Ultimate Care Mt Victoria have an interRAI assessment completed within three weeks of admission, however these were not consistently reviewed every six months.</p>	<p>Residents are required to have an interRAI assessment every six months, or as needs change.</p> <p>180 days</p>
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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.