# Melody Enterprises Limited

## 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:** Melody Enterprises Limited

**Premises audited:** Ultimate Care Rhapsody

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 15 October 2015 End date: 16 October 2015

**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:** 66

# 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 Rhapsody is situated in New Plymouth. The facility provides rest home and hospital level care services for up to 70 residents. There have been no changes to the ownership or the facility since the previous audit.

This is the second unannounced surveillance audit against the Health and Disability Services Standards for Rhapsody. It included a review of a sample of residents’ files, interview of residents, relatives and staff, and observation of the environment. The sampling process included an in-depth focus on the care of two residents through their stay. Information gathered was used to determine the effectiveness of care provided and the organisation’s systems.

There has been improvement in the operation of the facility since the last onsite audit and this reflects the work done by the new facility manager, with the organisation’s support, to ensure that the findings from the last audit were addressed.

The nine previous areas that required improvement have now been fully addressed. One new area for improvement was identified around the service not fully meeting a resident’s assessed need. One area of excellence has also been identified in the area of activities planning.

## 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. |

There is evidence that residents and families are notified of incidents when they occur. Detailed records are maintained recording communication with family members, which is confirmed in interviews.

There is a current complaints register which is maintained by the facility manager according to the organisation’s procedures for complaint management. There is easy access to the complaint management process.

## 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. |  | Standards applicable to this service fully attained. |

Ultimate Care Rhapsody is part of the Ultimate Care Group. The management team (a facility manager and clinical services manager) report to the wider organisation’s senior management team.

Ultimate Care Group’s quality and risk management system is well implemented at the facility. This includes the management of documents, reporting and recording of all adverse events, development of corrective actions, a comprehensive programme of internal audits and monitoring of the quality programme.

Human resources are managed following the Ultimate Care’s systems and a review of personnel files confirms that the systems are implemented. Safe staffing levels are maintained at the facility.

Five previous areas requiring improvement in relation to the quality and risk management systems of the facility (four) and the completion of training by staff (one) have all been addressed since the last on site audit.

## 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 low risk. |

Residents’ needs are assessed on admission by the multidisciplinary team. All residents’ files sighted provided evidence that needs, goals and outcomes are identified and reviewed on a regular basis; however an area identified as requiring attention relates to one resident’s needs not been fully attended to. A previous requirement for corrective action around care planning and service delivery has been addressed. Residents’ and families interviewed reported being well informed and involved.

An activities programme exists that includes a wide range of activities and involvement with the wider community. Implementation of a resident initiated activity has been identified as an area of continuous improvement.

Well defined medicine policies and procedures guide practice. Practices sighted are consistent with these documents. Areas previously identified as requiring corrective attention have been attended to.

The menu has been reviewed by a registered dietician as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. Residents have a role in menu choice and interviews with residents verified satisfaction with meals.

## 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. |

There is a current building warrant of fitness for the facility. There have been no alterations to the facility since the last onsite audit.

## 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. |

Ultimate Care has a suite of policies and procedures on restraint minimisation and safe practice which are consistent with the required standard. The clinical services manager has a clear understanding of the restraint minimisation and safe practice processes and provides guidance to the restraint coordinator.

When needed residents have appropriate mobility equipment which they use voluntarily and as and when they choose. All appropriate documentation was in place to support the use of this equipment. Enablers have been consented to and residents who use them are monitored to ensure their wellbeing. The restraint minimisation and safe practice system is implemented at the facility.

## 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. |

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. Surveillance results are benchmarked with the organisation’s other facilities. The results of surveillance are reported through all levels of the organisation, including governance.

The previous area for improvement in relation to the infection control coordinator’s training has been addressed.

## 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 | 18 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 1 | 40 | 0 | 1 | 0 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk****(UA Negligible)** | **Unattained Low Risk****(UA Low)** | **Unattained Moderate Risk****(UA Moderate)** | **Unattained High Risk****(UA High)** | **Unattained Critical Risk****(UA Critical)** |
| **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 Ultimate Care Group (UCG) has an appropriate complaint management policy and procedure which meets the requirements of the standards. There is an electronic adverse event and complaint management system called ‘GOSH’, which is used throughout the organisation and is in use at Ultimate Care Rhapsody. The facility manager is responsible for logging complaints in this system and ensuring these are reported and managed. Complaints are risk rated and high and critical risk complaints are automatically escalated through to the senior management team and UCG’s audit and compliance team. The register which is maintained at the facility is current and records all actions in response to complaints. The annual resident and family survey indicates satisfaction with the complaints process. A complaint was made to the Health and Disability Commissioner by a family of resident prior to Ultimate Care Group purchasing and taking over Ultimate Care Rhapsody. This was finalised in June 2015. While the commissioner’s decision acknowledges that Ultimate Care Group was not the owner of the facility at the time of the circumstances which led to the complaint, Ultimate Care has apologised to the family of the resident as the current owners of Melody Enterprises, which is the legal name of Ultimate Care Rhapsody.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There are guidelines for communicating with residents, relatives and visitors which sets out expected behaviours of staff. These were observed during the audit with staff heard addressing people in a respectful manner and residents being given time to answer. Residents and family members interviewed reported that staff ensured that they are understood and communication is respectful. Open disclosure occurs according to the facility’s policy. Incident reports record that a family member has been notified when this has been requested, and this is verified in family communication and incident forms sighted. Staff members interviewed confirmed the notification of family members or other representatives when incidents occur. The facility manager and clinical services manager were interviewed and verify that interpreter services are used for residents when required. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | UCG is the governing body and is responsible for the services provided at the facility. The organisation has documented values, a mission statement and philosophy, which were displayed in the entrance area of the facility and in a range of documents and plans. The service philosophy is in an understandable form and was available to residents and their family / representative or other services involved in referring residents to the service. UCG has established systems in place which defines the scope, direction and goals of the organisation at UCG facilities, as well as the monitoring and reporting processes against these systems. The facility manager at Ultimate Care Rhapsody has been in the position since January 2015. She was previously the administration officer for six years and had worked in other positions at Ultimate Care Rhapsody for two years before that. The clinical services manager has been in the position for three months. He has come from another aged care facility where he held a similar position with management and quality responsibilities. Both managers have been supported by the organisation through the formal orientation period of their new roles and with ongoing support from the regional operations manager and the audit and compliance team members, and other facility managers and clinical service managers from the wider group. This has assisted the facility to address the issues identified at the surveillance audit conducted in December 2014. (Two of these managers were interviewed during this audit and are recorded in the additional management numbers). On the day of audit there were 66 residents, 15 hospital residents and 55 rest home residents. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The UCG Quality and Risk Management Plan is used to guide the quality programme and includes quality goals and objectives. Each facility has their own annual quality plan with objectives relevant to the ongoing activities in the facility. The January 2015 – January 2016 quality and risk management plan for the facility was reviewed with the facility manager. The objectives are consistent with the guidelines given in UCG’s policy on the development of quality objectives and areas which are contributing to ongoing improvement at the facility. The quality management system includes monthly quality improvement and staff meetings, internal audits with monitoring and reporting of the results of these through the UCG head office. Policies and procedures are available with systems in place for reviewing and updating these regularly, including a policy to update reviews and a document control policy.At interview with the facility manager she described the formal reporting systems. There are weekly and monthly reports to UCG Head Office. These include reporting against risks, any variations to budgeted hours, changes in staffing levels and projected expenditure. A range of reports were sampled with the manager and these have been consistently completed since she took on the role in January 2015. When indicated corrective action plans were raised to address any areas of concern or where improvements could be made. All completed internal audits which identified required improvements had corrective action plans developed. The incident and complaint reports also have sections for corrective action planning, and these are captured on the electronic GOSH reports. This provides an effective process for identifying trends and issues to be managed. Monitoring of the quality plan progress occurs through the head office team’s monitoring of internal audits, GOSH reporting, and the annual unannounced internal audit conducted by the audit and compliance Manager. This occurred at facility in July and the corrective actions identified at the audit were sighted during this external audit. The areas identified as requiring improvement have been addressed and closed out by the audit and compliance manager. A range of documents and records associated with the facility’s quality and risk management system were reviewed. All were consistent with the implementation of the quality management system. Staff members interviewed confirmed that they receive information about collated data, receive detailed information about responses to individual events and trends when these are identified. They consistently reported that there is an effective flow of information in responses to individual events, trends and systemic issues and when outbreaks have occurred.It is noted that since the new facility manager’s appointment the implementation of the quality and risk management system has been consistent and regular. All meetings have been held as required by the organisation’s schedule of committees and meetings. Minutes are recorded with an appropriate level of detail. The four previous findings raised in December 2014 have all been addressed and the organisation’s quality and risk management system is now fully implemented.  |
| 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.  | FA | The adverse event reporting system reviewed provided evidence of a planned and coordinated process. Staff document adverse, unplanned or untoward events on incident/accident forms which are then reported on the UCG quality system through GOSH. They are filed in residents’ files and as well as being recorded on the facility’s electronic GOSH register. All incidents were collated, reviewed and analysed at the monthly quality meetings and any corrective actions identified to improve service delivery and mitigate any risks.The GOSH incident register for 2015 and a sample of incidents from residents’ files were reviewed. These followed the required process with all actions and outcomes recorded, including notification of families. Staff members interviewed reported that the process enables them to manage individual events. The collation and analysis of events provides them with useful information about the types of events which occur and any trends or issues which arise. They also reported that these processes have improved in the last year and they are receiving regular and more useful information. Policy and procedures comply with essential notification reporting, including health and safety, human resources and infection control. The manager demonstrated a clear understanding of what is required for essential notification reporting and the appropriate authorities to contact. |
| 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.  | FA | The organisation has well described human resources management systems which include the recruitment and appointment of employees, orientation, training and on-going education, performance development and management, and for associated good employment practices.A review of personnel files confirmed that all required documentation is maintained and recruitment and selection practices have been followed. Appropriate validation of annual practising certificates is occurring, at employment and annually, both for employed staff and for contracted health professionals. All practising certificates were current to the time of the audit. Reference and police checking occurs during the recruitment process. There is a planned education programme which includes modules on restraint, the Code of Health and Disability Services Consumers’ Rights (the Code), infection prevention and control, challenging behaviours and restraint minimisation, wound care, back care, nutrition and continence. Annual medication competencies are included where indicated. All staff who are required to hold first aid certificates (this includes registered nurses and some senior caregivers) have current first aid certificates. The facility manager and clinical services manager share the planning of staff training and development, with the facility manager having overall responsibility for the annual training programme and the clinical services manager undertaking competency assessments and supervision of nursing and care staff. All caregivers complete ACE (Aged Care Education) training and certification programmes relevant to their roles. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Twenty four hour registered nursing cover is provided. In addition there are caregiving staff, two activities coordinators, one a trained diversional therapist, house-keeping, cleaning and kitchen staff and a trained cook who make up the full complement of staff at Ultimate Care Rhapsody. The manager completes all the rosters for the facility and uses the ‘allocation of staff/duty rosters’ tool which is used across UCG. This ensures the allocation for hours and staff meets the required levels to reflect the needs of the residents who are currently in facility. This is sent to the head office every Friday to show the level and skill mix rostered for the coming week. The manager completes all rosters ahead for a two week period and then rechecks just prior to each new week. If there are any queries the manager discusses these with the regional operations manager. The rosters showed sufficient staff levels and skill mixes appropriate to meet the current residents’ needs. Staff members interviewed reported that staffing levels are sufficient to be able to provide safe services to residents. |
| 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 | The medication management policy is comprehensive and identifies all aspects of medicine management. A safe system for medicine management was observed on the day of the audit. The staff member observed demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administers medicines are competent to perform the function they manage. Controlled drugs are stored in separate locked cupboards and checked by two nurses for accuracy in administration. The controlled drug register evidences stock checks and accurate records.The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range, and this addresses a previous corrective action request. The GP’s signature and date are recorded on the commencement and discontinuation of medicines. The three monthly GP review is recorded on the medicine chart. A previous corrective request around the documentation related to medication administration when varying doses are required has been addressed. Residents who self-administer their medicines have appropriate processes in place to ensure this is managed in a safe manner. Medication errors are reported to the clinical manager and recorded on an 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 is verified. Standing orders are not used. Any pro re nata (PRN) (as required) medication administered requires authorisation on the resident’s medication chart. PRN medication requests include indications for use. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian’s documented assessment of the planned menu. A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, is sighted. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme. A cleaning schedule is sighted as is verification of compliance. Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, sighted satisfaction surveys, observation and resident meeting minutes. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and assists in identifying the required support the resident needs to meet their goals and desired outcomes. A previous corrective action requirement for care planning to document the specific support the resident requires to meet desired outcomes in relation to wound care, insulin management and seizure management has been addressed.Care plans evidence service integration with progress notes, activities notes, and medical and allied health professionals’ notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to those concerned. Care plans are evaluated three monthly or more frequently as the resident's condition dictated. Interviews and documentation verified resident and family/whanau involvement. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Documentation, observations and interviews provided evidence that one of the nine residents’ reviewed was not receiving the required care to meet their needs. A previous corrective action requirement around wound care, insulin, and seizure management and assisting a resident to self-administer medications, has been addressed.All residents and family/whanau members, with one exception, expressed satisfaction with the care provided.There were sufficient supplies of equipment available that complied with best practice guidelines and meet the residents’ needs. |
| Standard 1.3.7: Planned ActivitiesWhere 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. | FA | Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate, and this is an area identified as one of continuous improvement. Residents’ meetings are held monthly. Meeting minutes and satisfaction surveys provide evidence that the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated daily and reported in the progress notes. If any change is noted it is reported to the RN. Formal care plan evaluations, following reassessment to measure the degree of a resident’s response in relation to desired outcomes and goals occur every three months or as residents’ needs change, and are carried out by the RN. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan. A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident’s general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The manager advises there have been no alterations to the building since the last audit and none were observed. The current building Warrant of Fitness is displayed in the main entrance and expires on 15 January 2016.In rooms where rest home and hospital care is provided, the rooms are large and of a sufficient size to accommodate any mobility equipment the residents may require. The environment has been purpose built as an aged care facility and is maintained appropriately.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA |  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | All staff are provided with education on infection prevention and control principals through the facility’s training programme. The clinical services manager is the infection control coordinator and has current and relevant infection control training appropriate for this role. Evidence of this was confirmed through sampling of personnel files. This addresses a previous area for improvement. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | In line with the infection prevention and control policy and procedures, monthly surveillance is occurring. This is collated each month and analysed to identify any significant trends or possible causative factors. Incidents of infections are entered into the company’s benchmarking programme with monthly graphs provided to highlight results and evaluate the effectiveness of the programme. These are discussed at the quality meeting and data presented at staff meetings. Any ongoing and corrective actions required are discussed and implemented as evidenced by meeting records, infection control records and staff interviews. Any immediate action required is presented to staff at shift hand over, at the time it occurs. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | UCG has a suite of policies and procedures to guide facilities in the management of restraints and enablers, should these be required by residents. The clinical services manager was interviewed on the day of the audit and the restraint coordinator interviewed by telephone as she was not rostered to work. There is a philosophy of restraint minimisation at Ultimate Care Rhapsody and there are systems and processes in place so that should restraints or enablers be required they can be used. Other staff members interviewed were familiar with the restraint policies, the voluntary use of enablers and the processes to be followed should either be required.The restraint approval group meets regularly, and any restraint use is reported and monitored through this group, the quality group and at staff meetings. Currently there are two residents who use enablers and these files were reviewed. All documentation and records relating to their enablers is current, is in line with the organisation’s procedures and use of the enablers is reviewed by the restraint approval group.  |

# 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 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Documentation, interviews and observation evidenced the resident was not receiving the required care to meet their needs. The facility and clinical manager responded immediately to these concerns. Discussion with the family was initiated. Appropriate interventions were documented and information passed on to care staff and RNs at handover. Follow up the next day ensured the concerns had been addressed and the care provided met the resident’s needs. This is rated as a low risk, as it was evidenced in one of nine residents’ reviewed, and was promptly attended to. | One of nine care plans did not describe the interventions required to meet the resident’s comfort needs. | Residents receive the assistance required to meet their ongoing needs.180 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.

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.3.7.1Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | A quality initiative was implemented after eight residents expressed a desire to participate in a project to support the neonatal unit by creating and putting together packs of items for premature babies. Some residents knit, one resident sews the bags from materials donated to put the items in and some residents pack the items into the bags. Resident’s arrange regular outings to the local hospice shop to access any materials required and contact businesses to source baby products if they are running short. Families assist with knitting or sourcing supplies. The group has now more than doubled in size. A visit from a member of the neonatal unit inspires them with the stories of the babies they have helped. A recent newspaper article has acknowledged the work these residents do. The residents have verbalised how they feel valued by being involved and contributing to something worthwhile. | A quality initiative was identified and implemented in response to an expressed interest by some residents, at a residents’ meeting. A formal review of the initiative has identified increased resident satisfaction and feelings of self-worth, following its implementation. |

End of the report.