# 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: 26 May 2016 End date: 26 May 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:** 42

# 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

The Ultimate Care Aroha provides residential care for up to 46 residents who require rest home, rest home dementia and hospital level care. The facility is operated by the Ultimate Care Group Limited.

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

There were seven areas requiring improvement from the previous audit relating to aspects of quality, staff recruitment, staff education, resident’s documentation, the activity programmes and aspects of the food service. Areas relating to aspects of quality including corrective actions and the use of correction fluid, the food service and activities have yet to be addressed.

There are additional areas requiring improvement from this audit relating to staffing levels, performance appraisals and assessments of residents.

## 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. |

Staff demonstrated an understanding of residents' rights and obligations. Information regarding residents’ rights, access to interpreter services and how to lodge a complaint is available to residents and their family. Staff communicated with residents and family members following any incidents/accidents as appropriate.

The facility manager is responsible for the management of complaints. A complaints register is maintained.

## 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. |

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

The facility is managed by an experienced and suitably qualified manager who is a registered nurse. The facility manager is supported by a clinical services manager who is responsible for oversight of the clinical service in the facility.

There is an internal audit programme. Risks are identified. Adverse events are documented on accident/incident forms. Combined quality and staff meetings are held and there is reporting of clinical indicators, quality and risk issues and discussion of any trends. Graphs of clinical indicators are available for staff to view along with meeting minutes.

There are policies and procedures on human resources management and processes are followed. Health professionals have current annual practising certificates. An in-service education programme is provided for staff and attendance sheets are held on file. Staff are also encouraged to complete the New Zealand Qualifications Authority Unit Standards. Review of staff records evidenced individual education records are maintained.

There is a documented rationale for determining staffing levels and the skill mix in order to provide safe service delivery that is based on best practice. The facility manager and the clinical services manager are rostered on call after hours. Staff reported there are adequate staff available in all areas with the exception of the dementia unit 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. |

The assessment of residents’ needs, the development of individualised and detailed care plans and evaluation of progress towards identified goals are undertaken by registered nurses in a timely manner. Medical admissions are completed by doctors within required timeframes, residents are reviewed regularly and referred to a doctor promptly if their clinical needs change.

The clinical manager is on site weekdays. Registered nurses are on duty 24 hours a day and provide support and guidance to the caregiving staff. Continuity of care is promoted by staff having verbal handovers at the start of each shift, a written handover sheet, and the updating of residents’ progress notes each shift. While all residents have had an interRAI assessment since admission, a number of re-assessments are now overdue.

All aspects of medication management comply with legislative requirements and best practice guidelines. Medications are only administered by registered nurses, all of whom have completed medication competency assessments.

A qualified diversional therapist leads a varied activities programme, including a separate activities programme for residents in the secure dementia wing.

Aspects of kitchen management, such as the monitoring of fridge/freezer temperatures and the implementation of cleaning schedules remain areas for improvement. Well-established processes are in place to monitor residents’ nutritional status, and residents reported their satisfaction with meals provided to them.

## 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. |

A current building warrant of fitness is displayed. There have been no changes to the layout of the building that has required a change to the approved evacuation scheme.

## 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. |

The service has clear policies and procedures which meet the requirements of the restraint minimisation and safe practice standard. There were residents using restraint during the audit. Staff education has been provided and competencies are current. The restraint approval committee undertakes regular quality reviews to ensure compliance with policies and to consider all aspects of restraint and enabler use. The restraint/enabler register is current.

## 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. |

Effective processes and systems are in place for infection surveillance and for reporting of and responding to surveillance results. Surveillance data is benchmarked both internally and also with other UCG facilities. A range of strategies are used to ensure staff are aware of surveillance results.

## 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 | 10 | 0 | 3 | 3 | 0 | 0 |
| **Criteria** | 0 | 33 | 0 | 3 | 3 | 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 complaints and there are systems in place to manage the complaints processes. A complaints register is maintained. There is evidence that complaints are managed appropriately.  Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes. The complaints process was readily accessible and displayed. Review of the quality and staff meeting minutes provided evidence of reporting of complaints to staff. Care staff confirmed this information is reported to them via staff meetings.  There has been one complaint received by the DHB since the previous audit relating to staffing levels. Documentation evidenced the DHB has investigated the complaint, that the complaint was not substantiated and has been closed. There have been no investigations by the Health and Disability Commissioner (HDC), Ministry of Health, the Accident Compensation Corporation (ACC), Police or Coroner since the previous audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family confirmed communication with staff was open and effective. Family are consulted and informed of any untoward event or change in care provision of their relative. The collated resident and family survey for 2015 confirmed effective communication with residents and families. Families stated they are also included in care reviews and review of residents’ files confirmed this.  The service had an open disclosure policy which guides staff around the principles and practice of open disclosure. Education on open disclosure is provided at orientation and as part of the education programme. Staff confirmed their understanding of open disclosure. Communication with relatives was documented in the residents’ files. Incident/accident forms evidenced families being informed when incidents occurred.  Staff were observed to introduce themselves to residents upon entering the resident's room and staff are identifiable by their name badge.  The clinical services manager advised interpreters are accessed through the local DHB if required. |
| 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 Ultimate Care Group (UCG) head office.  The facility is managed by a facility manager (FM) who is a registered nurse and has been in this position since April 2016. The facility manager has managed another aged care facility in the region and prior to that has held other management positions in the health sector. The facility manager is supported by an experienced clinical services manager who is a registered nurse and was appointed to their current position in January 2016. The clinical services manager (CSM) has worked in other aged care facilities as a clinical manager including facilities with dementia units. The clinical services manager is responsible for oversight of clinical care at Ultimate Care Aroha (Aroha). Support is also provided by personal from UCG’s head office.  The managers' personal files and interview of the managers evidenced they have undertaken education in relevant areas. The managers reported they have received an orientation to their positions and documentation in the managers’ files confirmed this.  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 12 dementia level care residents.  Aroha has contracts with the DHB for ‘Aged Related Residential Care’, ‘Long Term Chronic Care’, and Respite Care and Day Care’.  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 Moderate | A quality and risk management plan guides the quality programme and includes goals and objectives. There was evidence that quality improvement data is being collected, collated, and analysed to identify trends and improve service delivery. There was evidence of corrective action plans being developed, implemented and reviewed for deficits identified in meeting minutes and accident/incident reports. There is an internal audit programme and completed internal audits for 2015 and 2016 were reviewed. However, internal audits do not consistently evidence documentation around corrective action plans. The requirement from the previous audit remains open. Correction fluid was being used in quality documents, including internal audits and staff signing sheets.  The collated relative and resident satisfaction surveys for 2015 indicated that residents and families are satisfied with the services provided.  Monthly quality and staff meetings are combined and there is reporting of various clinical indicators and quality and risk issues. 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 reference legislative requirements. Policies and procedures are reviewed and are current. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for the service delivery.  Actual and potential risks are identified and documented in the hazard register. The hazard register identifies hazards and shows the actions put in place to minimise, isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The facility manager is responsible for hazards. Staff confirmed they understood and implemented documented hazard identification processes. |
| 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 | 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. Review of the forms evidence all sections were being completed consistently, addressing the requirement from the previous audit.  The clinical services 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 | There are human resources management policies and procedures. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, completed orientation, competency assessments and police vetting. Reference checks were evidenced on the files sampled; this requirement from the previous audit is closed.  There is an orientation/induction programme and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided.  The clinical services manager is responsible for managing the in-service education programme. There was good evidence that education has been provided to staff since the last audit. In-service education is provided at least monthly and by way of online learning. The clinical services manager stated that staff have also been booked to attend external education. Individual records of education are maintained and competency assessments are current including restraint. Care staff demonstrated good knowledge relating to the difference between a restraint and an enabler. This requirement from the previous audit is closed.  Care staff are encouraged to complete a New Zealand Qualification Authority education programme. Staff have either completed or commenced the specific dementia modules.  Not all staff performance appraisals are current. Annual practising certificates are current for staff and contractors who require them to practice.  The clinical services manager and one of the seven registered nurses have completed the interRAI education. The clinical services manager advised three registered nurses have been booked to complete the interRAI course. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate | 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 with a senior RN are rostered on call after hours. The minimum number of care staff on duty is during the night shift and consists of one registered nurse and two caregivers (one in the dementia unit and one in the rest home/hospital areas).  Care staff reported that they are able to get through their work. Residents and families reported there are enough staff on duty to provide adequate care. The roster evidenced there is one caregiver on duty in the dementia unit on the morning shift with a ‘floating’ caregiver to cover all areas. Interview of the managers during this audit confirmed the floating caregiver is helping care staff outside the dementia unit, due to the workload. As a result, there is one caregiver in the dementia unit to care for residents and this was observed during the audit. Due to the physical layout of the dementia unit this practice is not safe for 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 | All aspects of medication management comply with legislative requirements and safe practice guidelines. The facility uses an electronic medication management system. All medication charts reviewed contained a current photograph of the resident. Medications were appropriately prescribed, and discontinued medications initialled and dated. Three-monthly reviews of medication have been undertaken and medication administration records were complete. The service does not use standing orders. There are currently no residents who are self-medicating. An observation of a medication round confirmed that medications were administered in a safe and appropriate manner.  Medications are supplied to the facility using the robotics system. These packs are checked against the medication chart by a RN (as was sighted) on arrival to the service. Surplus and expired medication is returned to the pharmacy. Weekly stocktakes of controlled medications are documented in the controlled drugs register, with a pharmacy review of controlled medications last undertaken in March 2016. |
| 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 | Issues identified in kitchen management during the last audit are still outstanding in relation to hygiene and food safety.  The kitchen caters for a range of nutritional requirements and specialised crockery and cutlery, such as lip plates and feeding cups, are available to promote residents’ independence. A six weekly menu, with summer and winter options, is supplied by the organisation. A dietary profile is completed when residents are admitted and details of their likes/dislikes and special nutritional needs recorded on the kitchen whiteboard. Residents are weighed monthly and evidence was sighted in the clinical records of ongoing review and action in response to any resident’s weight loss/gain. Three dining areas are available for residents or they may have meals in their own room if they wish.  Residents and family members expressed their satisfaction with the meal service. Resident satisfaction with food is monitored through the annual resident survey, monthly residents’ meetings and informal feedback from residents. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Registered nurses are on duty 24 hours a day who provide support and guidance for care delivery staff. There was evidence in all residents’ records reviewed of regular, timely and comprehensive ongoing assessment of needs which then informed the provision of care services. Care plans were comprehensive, and included detailed strategies to address identified needs. Residents’ progress notes are updated at least every shift. A doctor who visits the facility at least weekly expressed satisfaction with the standard of care provided to residents and confirmed they were updated in a timely manner when residents’ needs changed. |
| 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 Low | A qualified diversional therapist, with more than two years’ experience, was appointed to lead the activities programme in March 2016. Residents’ previous and current interests are assessed on admission and individual activity plans completed, although not all plans have been developed or evaluated within required timeframes.  Two activities plans, one for rest home and hospital residents, the second for residents in the secure dementia unit, are developed for residents each week, reflecting the identified activities needs. Both activities programme include a range of activities, including exercises, quizzes, crafts, games, reminiscence, current event, entertainment, church services, outings and ‘happy hour’. Residents in the dementia unit have a detailed, individualised and meaningful activities plan, which includes details of activities suitable for the 24-hour period. These plans, together with the updated activities programmes, address the areas for improvement identified at the last audit.  Residents interviewed expressed their enjoyment of the activities programme and commented on the variety of activities now available. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ progress towards identified goals is consistently evaluated in a timely and detailed manner, as sighted in all care plans reviewed. The nursing care plans for residents are reviewed by registered nurses at least three monthly and more frequently if clinically indicated. Evaluations are detailed and care plans are updated to reflect any identified changes. Short-term care plans were also evident in the care plans reviewed, and included regular evaluation until the issue was resolved, or was transferred to a nursing care plan. |
| 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. There have been no building alterations since the previous audit. |
| 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 surveillance of an appropriate range of infections is managed in a structured and systematic manner. When an infection is identified, an infection notification form is developed and given to the clinical manager who is the infection control coordinator. The results of the infection surveillance are collated, and entered into the organisation’s electronic ‘GOSH’ system, and benchmarked both internally and across UCG facilities.  There was evidence of a range of strategies in place to ensure that staff were kept updated about the results of the infection surveillance programme. These include the documentation of discussions about surveillance results at staff and the registered nurses meetings and graphs being developed and displayed for staff in the staff room. The infection control coordinator also advised that surveillance information is also shared with staff at handover meetings. |
| 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 CSM is the restraint coordinator and 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. |

# 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 | There was evidence of corrective action plans being developed, implemented and reviewed for deficits identified in meeting minutes and accident/incident reports. There is an internal audit programme and completed internal audits for 2015 and 2016 were reviewed. However, internal audits do not consistently evidence corrective action plans, who is responsible, the timeframe for completion, close out and review.  Correction fluid was evidenced in quality documents including internal audits and staff meeting minutes to correct mistakes made by staff. | Internal audits do not always evidence corrective action plans following deficits identified, who is responsible, timeframes for completion, close out and review.  Correction fluid was evidenced in quality documents including internal audits and staff meeting minutes to correct mistakes made by staff. | Corrective action plans are consistently developed and implemented for deficits identified following completed audits and that the person responsible, timeframes, close out and review is documented.  Cease the practice of using correction fluid to rectify mistakes made on quality documents.  90 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | There are human resources management policies and procedures. Job descriptions which outline accountability, responsibilities and authority, employment agreements, completed orientation, reference checks, competency assessments and police vetting were evidenced on staff files. Four of the seven staff files evidenced current performance appraisals. | Current performance appraisals were not evident on all staff files sampled. | Provide evidence that all staff have current performance appraisals.  180 days |
| Criterion 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Moderate | The rosters show one caregiver on duty in the dementia unit on the morning shift with a ‘floating’ caregiver to cover all areas. Interview of the managers during this audit confirmed the floating caregiver is helping care staff outside the dementia unit, due to the workload in those areas. As a result, there is one caregiver working in the dementia unit to care for residents. Observation evidenced the caregiver was busy showering a resident and there was no staff member available at the other end of the dementia unit where a number of residents were. Due to the physical layout of the dementia unit, this practice is not safe for residents.  Care staff reported they are able to get through their work. Residents and families reported there are enough staff on duty to provide adequate care. | Due to the floating caregiver being required to help other staff in the hospital/rest home areas, there remains one caregiver to care for the residents in the dementia unit on the morning shift. When the one caregiver is showering residents for example, there is no staff member available for residents who are in the dinning/lounge areas situated at the other end of the unit. | Review the roster and confirm there are adequate numbers of staff in the dementia unit during the morning shift, so that residents are provided with a safe service.  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 kitchen has recently experienced a number of staff changes and currently has a relief cook until the newly-appointed food services manager commences employment in early June. The facility manager advised that the new food services manager is experienced and appropriately qualified for that role. Food procurement, the disposal of food and the storage of food supplies, such as dry goods and tinned items, are consistent with legislation and guidelines.  Aspects of food storage and kitchen hygiene identified as areas for improvement in the previous audit have not yet been addressed. An internal audit in March 2016 which identified a number of similar issues related to kitchen management had not been followed up. Refer also to criterion 1.2.3.8. Although cleaning schedules have been developed since the last audit, implementation of these schedules had not been documented for a number of weeks. Two of the fridges required cleaning. The temperatures of the fridges, freezers and chillers were not consistently recorded. The facility manager confirmed that the two cooks have not completed Unit Standard 167 related to safe food management practices. Chipped paint was noted on several work surfaces, together with several small breaks in the floor covering. | Fridge/freezer temperatures are not being consistently monitored; there was no documented evidence of the implementation of cleaning schedules over the past month; two fridges were not maintained in a hygienic manner; leftover food or food past the best-by date was not disposed of in a timely manner; food temperatures were not consistently recorded prior to serving; two cooks have not completed food hygiene qualifications and work/floor surfaces were not fully impervious. | All aspects of kitchen management, including the storage of food, the implementation of cleaning schedules, staff qualifications/education related to food hygiene, ensuring work/floor surfaces are impervious, and the monitoring of fridge and freezer temperatures, comply with facility policies and best practice.  90 days |
| Criterion 1.3.3.3  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. | PA Low | The assessment, planning, provision and evaluation of service delivery are completed within timeframes that safely meet the needs of residents, with the exception of the interRAI assessment.  Two staff members are trained as interRAI assessors, with three staff currently on the waiting list for interRAI training. While all residents have had an interRAI assessment completed since admission, the registered nurse advised that 26 re-assessment are now overdue. Evidence was sighted in the residents’ records of the integration of a range of relevant information informing care planning, including interRAI assessment findings. | Residents are being assessed comprehensively using hard copy assessment tools. While all residents have had an interRAI assessment completed, 26 re-assessments are overdue. | All residents have a current interRAI assessment.  180 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 Low | The activities programme has been organised to provide meaningful activities for residents across the facility and residents in the dementia unit have comprehensive and meaningful activities plans.  The diversional therapist reported there was a backlog of activities plans waiting to be completed when they were recently appointed to their position, and they are currently working to address this. Evidence was sighted of documentation supplied by the diversional therapist to the clinical manager in the past week in relation to approximately 20 plans which were outstanding, and the timeframes within which these plans will be completed. | Residents’ activities plans are not being developed/evaluated within required timeframes. | Residents’ activities plans are developed and evaluated within contractual timeframes.  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.

|  |
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| No data to display |

End of the report.