# The Ultimate Care Group Limited - Ultimate Care Aroha

## Introduction

This report records the results of a Certification 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: 13 December 2016 End date: 14 December 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

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. On the first day of audit there were 42 beds occupied.

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

There has been significant progress since the last audit and improvement overall is noted.

There are five areas requiring improvement from this audit relating to the management of complaints; on-going education for non-clinical staff; time allocated for planned activities and lack of outings in the community; the availability of snacks to residents in the dementia unit over the 24-hour period, and the large water filled pot holes in the drive that runs parallel to the facility.

## Consumer rights

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

The Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive Māori health plan and related policies. There is no evidence of abuse, neglect or discrimination and staff understand and implement related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has strong linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

The facility manager is responsible for the management of complaints and a complaints register is maintained. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

## Organisational management

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| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of 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 system are fully implemented at Ultimate Care Aroha and include a documented scope, direction, goals, values, and a mission statement. Systems are in place for monitoring the service, including regular reporting by the facility manager and clinical services manager to head office.

The facility is managed by a facility manager who is a registered nurse. A clinical services manager/registered nurse supports the facility manager and is responsible for oversight of the clinical services.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Accident/incident forms and quality meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Quality, staff, registered nurses and resident’s meetings are held on a regular basis.

The hazard register evidenced review and updating of risks and the addition of new risks. The health and safety representative has completed an update on the Health and Safety at Work Act (2015) requirements.

Human resource processes are followed. There are policies and procedures on human resources management. Staff have the required qualifications. An in-service education programme is provided and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on best practice. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff and a designated general practitioner. On call arrangements for support from senior staff are in place.

Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents’ records are maintained in using an integrated (electronic and hard copy) file.

## 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 low risk. |

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents’ needs are assessed by the multidisciplinary team on admission within the required timeframes. 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 demonstrated 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. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by a diversional therapist, provides residents with a variety of individual and group activities.

Medicines are managed according to policies and procedures based on current good practice and are consistently implemented using an electronic system. Medications are administered by registered nurses, all of whom have been assessed as competent to do so.

Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

All building and plant complies with legislation. A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

Apart from one double bedroom, all bedrooms provide single accommodation. Adequate numbers of bathrooms and toilets are available. There are lounges, dining areas and alcoves. External areas for sitting and shading are provided. There is a secure external area provided for residents who reside in the dementia unit.

An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site. Cleaning and laundry systems, undertaken on site, are effective.

## 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 that meet the requirements of the restraint minimisation and safe practice standard. There were residents using restraint and an enabler during the audit. Appropriate documentation, including a current restraint register, is in place.

## 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. |

The infection prevention and control programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent and manage infections. Specialist infection prevention and control advice can be accessed from an external advisor, the District Health Board and the public health service. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 45 | 0 | 4 | 1 | 0 | 0 |
| **Criteria** | 0 | 96 | 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](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 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Ultimate Care Aroha has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent form including for photographs, outings, collection and sharing of information and residents names on doors.  Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented where relevant in the resident’s record. Staff demonstrated their understanding by being able to explain situations when this may occur. All residents in the secure unit had an enacted EPOA.  Staff were observed to gain consent for day to day care on an ongoing basis. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception and outside the hospital lounge. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.  Staff are aware of how to access the Advocacy Service. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family.  The facility has unrestricted visiting hours and encourages visits from residents family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents on admission and there is complaints information and forms available within the facility.  The complaints register showed nine complaints have been received since the previous audit. Not all documentation was complete for all the complaints. Right 10 of the Code had not been followed relating to one complaint in that a written response to the complaint had not been sent to the complainant.  The facility manager is responsible for the management and follow up of complaints. Staff interviewed confirmed a good understanding of the complaint process and what actions are required.  The facility manager (FM) reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, DHB, Accident Compensation Corporation (ACC), Coroner or Police since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, discussion with staff and by attendance of an Advocacy Service representative at resident and family meetings. The Code is displayed in all three areas of the facility together with information on advocacy services, how to make a complaint and feedback forms. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff understood the need to maintain privacy and were observed doing so throughout the audit (eg, when attending to personal cares, ensuring resident information is held securely and privately and exchanging verbal information). All residents have a private room. A whanau room is available for larger group meetings.  Residents are encouraged to maintain their independence by being offered choices during everyday interactions. Each plan included documentation related to the resident’s abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff interviews and training records. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Staff support the four residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. Current access to resources includes the contact details of local cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. The Māori resident and family interviewed reported that staff acknowledge and respected individual cultural needs. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident’s personal preferences, required interventions and special needs were included in all care plans reviewed (eg, religious beliefs, nutritional and spiritual practices). A resident satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met and this supported that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner also expressed satisfaction with the standard of services provided to residents.  The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct in both the staff orientation booklet and their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through clinical leadership based on evidence based policies, input from external specialist services and allied health professionals. For example, hospice/palliative care team, the diabetes nurse specialist, wound care specialist, dietitians, services for older people, seating specialists, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported they receive management support for external education and access their own professional networks, such as web based forums, to support contemporary good practice.  Evidence of good practice was sighted in the comprehensiveness of documentation in care planning and management plan of a resident with a multi-resistant infection. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their/their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in resident’s records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Interpreter services can be accessed when required. Staff knew how to do so, although reported this was rarely required due to all present residents ability to speak English. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the service provided at Ultimate Care Aroha. A quality and risk management plan that includes a business plan was reviewed and includes a mission and vision statement, core values, quality objectives, quality indicators and quality projects and scope of service. An organisational flowchart shows the structure and reporting lines within the organisation. The service philosophy is in an understandable form and was available to residents and their family / representative or other services involved in referring clients to the service.  The Ultimate Care Group has established systems in place which defined 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’s reports to UCG head office includes, but is not limited to, reporting on occupancy, staffing and human resources management, environmental and property reports, financial reporting, interRAI assessments, and general comments. Daily reporting to UCG head office is via an electronic database which is also used by the clinical services manager (CSM) to input clinical indicators.  The facility manager (FM) has been in the position since April 2016. The facility manager is a registered nurse (RN) and has managed another aged care facility prior to the current appointment. They have also held management positions in the wider 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, including dementia level care as a clinical manager and is responsible for oversight of clinical care at Ultimate Care Aroha. The senior management team from UCG head office also provide support as required.  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.  Ultimate Care Aroha is certified to provide hospital, rest home dementia and rest home level care. On the day of this audit there were 16 hospital level residents,12 rest home level residents and 14 dementia level care residents. The FM advised that five bedrooms in the rest home area have been approved by the Ministry of Health as dual purpose rooms (rest home or hospital level care).  Ultimate Care 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 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of the facility manager, the clinical services manager deputises. When the CSM is absent, the senior RN takes responsibility for clinical overview. The FM, the CSM and senior RN confirmed their responsibility and authority for these roles. |
| 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. | FA | A quality and risk management plan guides the quality programme and included goals and objectives. An internal audit programme is in place and completed internal audits were reviewed. Quality, RN, staff and resident meetings are held monthly. Meeting minutes were reviewed and these were available for review by staff and residents.  Clinical indicators and quality improvement data was recorded on registers and forms and is entered in to the electronic system daily. Quality data is being analysed and trends identified. The CSM reported they discuss any trends at the various meetings and a monthly clinical report produced by the CSM evidenced a comprehensive breakdown of quality data including graphs and bench marking with other UCG facilities and another provider of aged care facilities. Corrective actions are developed and implemented to improve service delivery following completion of internal audits, satisfaction surveys and meetings. Adverse events are documented on accident/incident forms and are retained in the residents’ files.  The Ultimate Care Group policies and procedures are fully implemented at Ultimate Care Aroha. Policies and procedures were reviewed that are relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. The care plan policy includes interRAI requirements. Policies / procedures were available with systems in place for reviewing and updating the policies and procedures regularly, including a policy for document update reviews and document control policy. The clinical advisory panel from UCG is responsible for reviewing policies and procedures. Staff signing sheets demonstrated staff had been updated on new/reviewed policies, and this was confirmed during interviews of care staff. Care staff confirmed the policies and procedures provided appropriate guidance for the service delivery and they were advised of new policies / revised policies.  Actual and potential risks are identified and documented in the hazard register, including risks associated with human resources management, legislative compliance, contractual risks and clinical risk and showed the actions put in place to minimise or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The health and safety coordinator is responsible for hazards and demonstrated good knowledge. 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. The clinical services manager reviews these. The original is kept in the residents’ files. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.  There is an open disclosure policy. Residents’ files evidenced communication with families following adverse events involving the resident, or any change in the resident’s condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative’s condition.  Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The FM advised there have been no essential notifications (Section 31) made 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 | Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.  The education programme is the responsibility of the CSM. The CSM is responsible for providing on-going education to clinical staff and there was evidence that this has occurred. It is the responsibility of the FM to provide on-going education to non-clinical staff, however staff files, the education spreadsheets and interview of non-clinical staff evidenced not all non-clinical staff have received on-going education. Individual records of education are maintained electronically as are competency assessments including restraint and medicine management. Staff files evidenced education certificates. Three RNs are interRAI competent and one RN is currently completing the course. Care staff have completed the dementia specific modules, apart from two staff members who are recent employees and they are booked to undertake this education.  The CSM advised a New Zealand Qualification Authority education programme will be re-introduced in the new year for staff to complete.  An orientation/induction programme is available 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 and annually thereafter. Orientation for staff covers the essential components of the service provided.  Staff performance appraisals are current. Annual practising certificates are current for all staff and contractors who require them to practice.  Care staff confirmed they have completed an orientation, including competency assessments. Care staff also confirmed their attendance at on-going in-service education and currency of their performance appraisals. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery. An electronic system is used that is based on best practice. The CSM and senior RN reported they develop and review the rosters for clinical staff and consider dependency levels of residents and the physical environment. The minimum number of staff is provided during the night shift and consists of one RN and two care givers, one in the dementia unit and one in the rest home/hospital area. The FM and CSM are on-call after hours. Care staff interviewed reported there was adequate staff available and that they can get through the work allocated to them. Residents and families interviewed reported the number of staff on duty is adequate to provide them or their relative with safe care. Observations during this audit confirmed adequate staff cover is provided. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | 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.  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. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the CSM or FM. They are also provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and general practitioner (GP) for residents accessing respite care. All residents in the secure unit had specialist documentation to verify this service was required.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB’s ‘pink envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records, advanced directives and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. Family of a resident recently transferred reported being kept well informed during the transfer of their relative. |
| 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 current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  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 six monthly and on request.  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.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted include 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 electronic medicine chart.  There are no residents who self-administer medications at the time of audit.  Medication errors are reported to the CSM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified. |
| 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 Low | The food service is provided on site by a qualified chef/cook and kitchen team, 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.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.  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. Residents in the secure unit do not always have access to food and fluids 24 hours per day, seven days per week to meet their nutritional needs.  Special equipment, to meet resident’s nutritional needs, is available.  Evidence of some residents’ dissatisfaction with meals recently is evidenced by satisfaction surveys, interviews and resident and family meeting minutes. Evidence was sighted of corrective actions implemented around areas of dissatisfaction. Satisfaction with meals at the time of audit was verified by resident and family interviews, and observation. 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. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CSM. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of three trained interRAI assessors on site. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed.  Care plans evidence service integration with progress notes, activities notes, and medical and allied health professional’s notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | 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 of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. |
| 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 | The activities programme is provided Monday to Friday, from 8.30am-4.00pm by a qualified diversional therapist (DT) holding the National Certificate in Diversional Therapy.  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 six monthly care plan review.  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, however activities are limited by the time allocated for them to take place and the unavailability of a suitable van to provide outings. The activities programme is discussed at residents’ and family meetings and minutes indicate residents’ and family input is sought and responded to. Dissatisfaction with the amount of entertainment provided has been addressed by an increase in the budget. Resident and family satisfaction surveys demonstrated some dissatisfaction with the programme. Residents interviewed confirmed they find the programme enjoyable, however the residents did feel the availability of the diversional therapist was often limited due to her attending to other residents.  Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. A twenty-four-hour care plan identifies activities that can be offered to residents by care staff, when residents are most physically active and/or restless. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations, occur every three months in conjunction with clinical assessments and the six-monthly interRAI reassessment or as residents’ needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted of short term care plans being consistently reviewed and progress evaluated as clinically indicated 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. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a ‘house doctor’, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are documented processes for the management of waste and hazardous substances. Incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets were sighted throughout the facility and accessible for staff. The hazard register is current.  There was protective clothing and equipment in the sluice rooms and laundry that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a good understanding of processes relating to the management of waste and hazardous substances. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | A current building warrant of fitness is displayed. There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. Residents confirmed they can move freely around the facility and that the accommodation meets their needs.  There is a proactive and reactive maintenance programme and the buildings, plant and equipment are maintained to an adequate standard. Maintenance is undertaken by a maintenance person who has a good understanding of their responsibilities. The testing and tagging of electrical equipment and calibration of bio-medical equipment is current.  There are external areas available that are safely maintained and are appropriate to the resident groups and setting. A secure court yard and gardens are available for residents residing in the dementia unit. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside, apart from the driveway which has large water filled pot holes in it.  Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of toilets and bathroom facilities throughout the facility. Residents and families reported that there are sufficient toilets and they are easy to access.  Appropriately secured and approved handrails are provided and other equipment is available to promote residents’ independence. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There is adequate personal space provided for residents and staff to move safely around the bedrooms. Residents and families spoke positively about their or their relative’s accommodation. Rooms are personalised with furnishings, photos, and other personal adornments.  There is adequate room in the facility to store mobility aids, such as mobility scooters, wheel chairs and walkers. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Areas are provided for residents to frequent for activities, dining, relaxing and for privacy. Residents, families and staff confirmed and observation evidenced these areas are easily accessed. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. Murals have been erected on the walls and doors in the dementia unit that depict different scenes. Families interviewed stated the murals have made the dementia unit feel more inviting and is a source of conversation with residents. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is washed on site. Residents and families reported the laundry is managed well and resident’s clothes are returned in a timely manner.  Ultimate Care Aroha is cleaned to an adequate standard. The cleaner demonstrated good knowledge of cleaning and laundry processes. Residents and families stated the facility is kept clean. Chemicals are stored in a locked cupboard. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an approved fire evacuation plan. There is an evacuation policy on emergency and security situations that covers all service groups at the facility. A fire drill takes place six-monthly. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted on the days of audit and all equipment had been checked within required timeframes.  There is always at least one staff member on duty with a current first aid certificate.  A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas BBQs. Back up lighting is available should there be a power outage.  There are call bells to alert staff. Residents and families reported staff respond promptly to call bells.  Contractors must sign in and out of the facility. The external doors are locked in the evenings and there are sensor lights for security at night. A security firm is also alerted if there is an attempted break-in. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Heat pumps and electric heaters provide heating. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from an external advisor. The infection control programme and manual are reviewed annually.  The clinical services manager is the designated infection control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the company’s quality and risk coordinator, facility manager, staff meetings and tabled at the quality meeting. This committee includes the facility manager, IC coordinator, the health and safety officer, and representatives from food services and household management.  Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for 11 months. They have undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from the community laboratory is available if additional support/information is required. The coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The IC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. An increase in the number of hand sanitisers around the facility has occurred recently and the implementation of blood and body spill kits. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2015 and include appropriate referencing.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Clinical staff interviewed verified knowledge of infection control policies and practices (refer 1.2.7.5). |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified clinical staff have received education in infection prevention and control at orientation and ongoing education sessions (refer 1.2.7.5). Education is provided by suitably qualified registered nurses, and the infection control coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing, increased fluids, the availability of ice blocks and advice to hospital and rest home residents about remaining in their room if they are unwell. |
| 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 | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the electronic resident management system/infection reporting form/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. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the quality committee. Data is benchmarked internally within the group.  New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Surveillance results are then shared with staff at the registered nurses and general staff meetings, as confirmed in meeting minutes sighted and interviews with staff.  There have been no outbreaks of Norovirus in the past twelve months. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are currently six residents using restraint and one resident using an enabler. The restraint register is current and updated. The policies and procedures have good definitions of restraints and enablers. The CSM is the restraint coordinator and demonstrated good knowledge relating to restraint minimisation. Staff demonstrated sound knowledge about restraint processes including the difference between restraints and enablers. The restraint coordinator and staff described how they have minimised the use of restraint through comprehensive assessments and review and the minimal use of equipment. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The CSM is the designated restraint coordinator. Responsibilities of the restraint coordinator and approval committee are clearly outlined. Restraints to be used for residents are approved by the restraint approval committee prior to commencing restraint. The restraint approval committee meets three monthly. Minutes of restraint meetings confirmed this.  Restraint use is discussed in the quality, RN and staff meetings and was evidenced in the meeting minutes. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Restraint assessment and application for the use of restraint forms are completed prior to commencing restraint. These were evidenced in the files of the residents using restraint. The risk factors were identified in the assessment and the purpose of the chosen restraint was documented. The desired outcomes were clearly documented in the long-term care plans. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service actively promotes the safe use of restraint. The restraint coordinator described their expectations relating to this. There is a current and updated restraint register which showed a reduction in the use of restraint since the last audit. The care plans ensure the resident’s safety while using restraint. Staff demonstrated good knowledge about restraints and strategies to promote resident safety while using restraint. The restraint minimisation policies and procedures are in place and are accessible for all staff to read. Monitoring forms reviewed evidenced residents are viewed at the required times. There were no restraint-related injuries reported. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Restraint use is evaluated at least three monthly and includes the requirements set out in this standard. Each resident using restraint is also reviewed at the approval group meetings, quality and RN meetings. Care staff confirmed that their feedback was obtained by the restraint coordinator and RNs when evaluating the restraint in use. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint approval group undertakes monitoring and quality review. Identified issues were discussed in these meetings as well as additional education that is required. Audits of restraint use have been completed as per the audit programme. The restraint minimisation and safe practice policies and procedures are reviewed regularly. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.13.1  The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA Low | Nine complaints have been received since the previous audit and six of these evidenced completed documentation, meeting Right 10 of the Code. Three of the complaints did not have a letter of response on the complaints file. The FM stated they were sure the letters had been written and sent to the complainants. The FM printed the letters off during the audit and this showed the complaints had been responded to within the 20-day timeframe. One other complaint had not been responded to and was outside the required timeframe. The FM wrote the letter and sent it to the complainant during the audit. | Right 10 of the Code has not always been complied with for all complaints received since the last audit. | Ensure the management of complaints meets Right 10 of the Code.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | The education programme is the responsibility of the CSM, however the CSM stated they are only responsible for the education of the clinical staff and the FM is responsible for educating the non-clinical staff. On-going education has been provided to clinical staff including core topics through on-line learning, education sessions and external education. Spread sheets, staff files and interviews of care staff confirmed this. Non-clinical staff on-going education is the responsibility of the FM. However, although non-clinical staff have received an orientation covering topics, staff files, the education spreadsheets and interview of non-clinical staff evidenced not all non-clinical staff have received on-going education including challenging behaviour, infection control and managing chemicals. Competency assessments for restraint and medicine management are current. | Not all non-clinical staff have received on-going education including but not limited to challenging behaviour, infection control and the management of chemicals. | On-going education that is relevant to their position is to be provided to non-clinical staff.  90 days |
| Criterion 1.3.13.2  Consumers who have additional or modified nutritional requirements or special diets have these needs met. | PA Low | Residents of the secure unit have their additional and modified nutritional needs met, however after supper and overnight access to food is limited. A ‘small’ plate of egg sandwiches is prepared by the cook should residents require food overnight. The pantry in the main kitchen is locked, with a small fridge in the main kitchen containing a few items.  Staff in the secure unit cannot leave the unit unattended and require a staff member from another area to get any items available and required if residents require food items additional to egg sandwiches. | Residents of the secure unit have limited access to additional nutritional requirements to meet their needs over 24 hours per day, seven days per week. | The secure unit has food available to meet residents’ additional needs at all times.  30 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 | A diversional therapist provides the activities programme across the three service streams, facilitating the needs of all residents in the secure unit, rest home and dementia. Observation, interviews and documentation verifies times when residents’ activity requirements are not being met, due to the DT providing activities in other resident areas.  Residents’ requests to go on outings in the community is not able to be provided due to the van being deemed unsuitable for the residents. A request for a new van has been made. | The activities for residents are planned and provided, however these are unable to develop and maintain residents’ strengths and interests due to limited time and resources allocated. | Activities are provided to develop, facilitate and maintain residents’ strengths, interests and skills.  90 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Moderate | The facility is on one level and hand rails are along passage ways in all the areas. The pathways and gardens are safe for residents and there is a secure garden and footpaths for the residents in the dementia unit to use. The driveway that runs parallel to the facility and leads to the hospital main entrance has large water filled pot holes. Residents’ meeting minutes evidenced they are concerned about the state of the drive. An incident/accident report showed that a resident’s family member had recently fallen while trying to avoid the pot holes.  The FM advised that UCG head office is aware and quotes for re-surfacing the drive have been received. The FM advised that during the audit the company expected to do the work made contact and they are to visit the site and discuss the work required. | The drive way that leads to the back of the facility and the hospital entrance is unsafe for residents and visitors and needs repairing/re-surfacing. | Provide a timeframe for the completion of the repairs/re-surfacing of the driveway.  60 days |

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

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

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

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

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End of the report.