# The Ultimate Care Group Limited - Ultimate Care Maupuia

## 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 Maupuia

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

**Dates of audit:** Start date: 7 March 2018 End date: 7 March 2018

**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:** 27

# 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 Maupuia provides residential care for up to 31 residents who require hospital and rest home level care. On the day of the audit there were 27 beds occupied. The facility is operated by the Ultimate Care Group Limited.

This surveillance audit was conducted against the Health and Disability Services Standards. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, families, management, staff, a general practitioner and other allied health professionals.

Two areas requiring improvement from the previous audit relating to the process for service delivery planning, short-term care plans and updating long term care plans have been addressed. The third requirement relating to names and designation of services providers making entries into residents’ records not always being legible remains open.

There are two new areas requiring improvement from this audit relating to weekly checks of controlled drugs and aspects of food storage, documentation concerning cleaning schedules in the kitchen and the cook’s qualifications.

## 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. |

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

The facility manager is responsible for the management of complaints 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 systems are fully implemented at Ultimate Care Maupuia 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 has a background in management and has been in the position for 18 months. The facility manager is supported by a clinical services manager who is a registered nurse. The clinical services manager is responsible for oversight of the clinical service in the facility.

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 meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address any areas that require improvement. Quality, health and safety, and various staff and residents’ meetings are held on a regular basis.

The hazard register evidenced review and updating of risks and the addition of new risks.

Human resources processes are followed. 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 rostered on duty at all times. The clinical services manager and facility manager are on call after hours.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The multidisciplinary team, including a registered nurse, general practitioner and physiotherapist, assess residents’ needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are managed and administered by registered nursing staff who are competent to do so.

The food service meets the nutritional needs of the residents, with special needs catered for. A range of individual resident food likes/dislikes, as well as dietary and cultural needs, are accommodated. Residents reported they were very satisfied with the meals.

## Safe and appropriate environment

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

A current building warrant of fitness is displayed. There have been no structural alterations since the previous audit.

## Restraint minimisation and safe practice

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

The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were no residents using restraint and one resident using an enabler during the audit.

## Infection prevention and control

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

Well-developed processes and systems are in place for infection surveillance, and for reporting of and responding to surveillance results. Surveillance data is benchmarked both internally and also with other UCG facilities.

## 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 | 15 | 0 | 1 | 2 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 1 | 2 | 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 complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and there is complaints information and forms available throughout the facility. All complaints are entered into the electronic data base.  The complaints register showed five complaints were received in 2017 and none to date for 2018. Actions taken, through to an agreed resolution, were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible.  The facility manager is responsible for complaints management and follow up. Staff interviewed confirmed a sound 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, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police 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 members stated they are kept well informed about any changes to their own or 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 residents’ 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. Several languages are spoken by staff including te reo Māori, Tongan, Italian and staff use sign language to communicate with a Chinese resident and family members act as interpreters if needed. Interpreter services can be accessed via the nationwide interpreter services if required. Staff knew how to do so and brochures on the service were easily accessible. |
| 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 Maupuia. 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, 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 is available to residents and their family / representative or other services involved in referring clients to the service.  The Ultimate Care Group Limited 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 CSM and the RNs to input clinical indicators and incident/accidents.  The FM reported the regional manager meets with the FM at least monthly and has verbal contact twice a week. Regional meetings are held with all FMs and CSMs three monthly where various topics are discussed and peer support is active.  The facility manager (FM) has been in the position for 18 months. The facility manager has held management positions in the private sector and has owned a business. The FM is supported by an experienced clinical services manager (CSM) / registered nurse who has been in the role for 12 months. The CSM has experience in working in the aged care sector. The CSM is responsible for oversight of clinical care provided to residents. The senior management team from UCG head office also provide support as required.  Ultimate Care Maupuia is certified to provide 31 beds for hospital and rest home level care. On the day of audit there were nine hospital residents of which one resident is aged under 65 years and 18 rest home residents. The eight beds down stairs are rest home beds only and the 23 beds up-stairs have all been approved as dual-purpose beds and can accommodate either rest home or hospital residents.  The facility has contracts with the DHB for ‘Aged Related Residential Care’ and ‘Short Term Residential care’. The FM reported there is also a ‘Capital Support’ contract with the Ministry of Health for the resident under 65 years.  The FM reported HealthCERT has been notified of the change of FM and CSM since the previous audit. |
| 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 2018 guides the quality programme and included goals and objectives. Projects for Ultimate Care Maupuia 2018 includes unintentional weight management and falls prevention. An internal audit programme is in place and audits have been completed as scheduled.  Clinical indicators and quality improvement data were recorded on various registers and forms. Data is being collected, collated and comprehensively analysed to identify trends. The quality indicator analysis reports for January and February 2018 were reviewed and confirmed this. Corrective actions are developed and implemented to improve service delivery following completion of internal audits, surveys, incident/accidents, complaints and any deficits identified at the various meetings. There was evidence of monitoring to make sure corrective actions have been effective. The FM demonstrated good knowledge relating to quality and risk management. Graphs are generated, including benchmarking with other facilities within the group. The CSM was unavailable for interview on the day of audit.  Meeting minutes evidenced monthly staff, registered nurse (RN) and health and safety meetings. Quality meetings are held three monthly. Meeting minutes evidenced reporting of clinical indicators including analysis and trends. Staff confirmed they discuss these at their meetings.  The Ultimate Care Group policies and procedures are fully implemented at Ultimate Care Maupuia. Policies and procedures are relevant to the scope and complexity of the service, reflected current accepted good practice, and reference legislative requirements. The care plan policy includes interRAI requirements. Policies / procedures are 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. New/reviewed policies are an agenda item and discussed at the quality meetings. Staff signing sheets demonstrated staff have been updated on new/reviewed policies. Staff interviewed confirmed this. Staff also confirmed the policies and procedures provided appropriate guidance for service delivery and they were advised of new policies / revised policies.  A Health and Safety Manual is available that includes relevant policies and procedures. Actual and potential risks are identified and documented in the hazard register. The hazard register identifies hazards and showed the actions put in place to isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The health and safety coordinator is responsible for hazards. The health and safety representative was not available for interview. The FM demonstrated an understanding of health and safety requirements. 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. These are collated by the clinical services manager. The original is kept in the residents’ files. Documentation reviewed, and interviews of staff indicated appropriate management of adverse events. The RNs are responsible for entering all incident/accidents into the electronic data base as they occur. A monthly incident summary reflects all incidents/accidents occurring and the information is used to generate a monthly report from the collected data.  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. The 2017 satisfaction survey supported this.  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. | FA | Policies and procedures relating to human resources management are in place. Staff files are managed well and 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. There was good evidence of in-service education provided for staff and documentation showed this is provided at least weekly and includes external educators. Individual certificates of training including competencies are held on staff files. Attendance records are maintained electronically. Five RNs are interRAI trained and have current competencies. All RNs and the activities coordinator have a current first aid certificate.  There was no evidence that the newly appointed cook has completed food safety training. (see criterion 1.3.13.5).  The FM advised a New Zealand Qualification Authority education programme will be again available soon for staff who have not already completed the programme. An external assessor is available for the programme.  New staff are required to complete the orientation programme 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 were current. Annual practising certificates were current for all staff and contractors who require them to practice.  Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the 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 mix to provide safe service delivery. The policy includes the staffing requirement in-line with the contract with the DHB. A skills matrix is also included in the quality and risk management plan to help with rostering. An electronic programme is used to calculate staffing levels that is based on best practice. The rosters evidenced staffing levels exceed the minimum requirements. The FM reported the rosters are reviewed continuously with the CSM and dependency levels of residents and the physical environment are considered. The CSM is full time Monday to Friday, and registered nurse cover is seven days a week over the 24-hour period. There are three health care assistants (HCA) on the morning shifts with a fourth on when the day care residents visit the facility. Three HCAs are on the afternoon shifts and one HCA on the night shifts. Health care assistants also share the cleaning and laundry duties. The activities person works 35 hours per week and there are two cooks and a kitchen hand.  Staff interviewed reported adequate staff are 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. | PA Low | At the previous audit a finding was made in relation to the need to ensure all records are legible and the designation of the service provider is identifiable. A review of seven residents’ files during this audit identified this criterion remains an area for improvement. |
| 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. | PA Moderate | 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 electronic system for medicine management 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 medications are administered by registered nurses, who are assessed annually for their competence to perform this function. The RN advised that a review of a report of all ‘not administered’ medications is undertaken monthly, and follow-up action taken as necessary using an established process. A copy of the most recent report was sighted, and the RN described the actions taken in relation to that report.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. Medications sighted were within current use by dates. Clinical pharmacist input is undertaken through consultation with the general practitioner.  Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The required weekly checks of the controlled stock checks and accurate entries are not being undertaken consistently.  The records of temperatures for the medicine fridge were within the recommended range.  There were no residents who self-administered medications at the time of audit, although processes are in place to ensure this can be managed in a safe manner if required. |
| 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 | The food service is provided on site by a qualified chef who has very recently been appointed to this position. The chef advised they had completed food safety training, but their staff file did not contain a copy of their qualifications or certificates. The menu 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 within the last two years.  All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines. The storage of dry goods, such as sugar and flour, requires improvement, as is the monitoring of kitchen fridge/freezer temperatures, and the implementation/documentation of planned cleaning schedules. The Facility Manager advised that a food safety plan specific to the facility is currently under development.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident’s nutritional needs, is available.  Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and from residents’ meeting minutes reviewed. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a dignified manner. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals’ 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 an appropriate standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels 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. | FA | The activities programme is coordinated by an activities officer who has been in this role for twelve months. The officer is in the process of enrolling for the national Certificate in Diversional Therapy. They are supported in their role by two volunteers.  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 multidisciplinary review.  Activities reflect residents’ goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents’ meetings, annual satisfaction surveys, and informal feedback after activities. Residents interviewed confirmed they find the programme interesting and varied. |
| 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 in conjunction with the six-monthly interRAI reassessment and multidisciplinary review, or as residents’ needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds and other medical events. When necessary, and for unresolved problems, long term care plans are added to and updated. This has addressed an area previously identified as requiring improvement. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The current building warrant of fitness expires on the 10 November 2018. There have been no structural alterations undertaken 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 | Surveillance is appropriate to that recommended for long term care facilities and includes a range of relevant infections. The Infection Control Coordinator outlined the processes for reporting any suspected infections. Infection control forms and plans were seen in three of the clinical files reviewed. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.  Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Trends are identified, and results analysed in conjunction with the Clinical Services Manager and reported to the Facility Manager. Copies of these reports were sighted. Results are also reported to the three-monthly Infection Control Committee meetings. Surveillance results are also reported to staff at handover meetings, and within the regular staff meetings. Surveillance data is also entered into the group’s data base and benchmarked within the group. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The policy has a section on enablers that includes a definition, assessment and evaluation. The FM reported the use of restraint has been a focus with the aim of minimising restraint use. Low beds have been purchased for residents and currently there are no residents using restraint. One resident is using an enabler. Staff interviewed demonstrated knowledge of what an enabler is, and the process should a patient request an enabler. Staff have received on-going education relating to challenging behaviours, enablers and restraint. |

# 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 1.2.9.9  All records are legible and the name and designation of the service provider is identifiable. | PA Low | Seven resident files were reviewed. Resident progress notes are updated each shift by staff. Entries made by registered nurses in the progress notes include the use of a stamp with their name and designation. However, in each of the seven files reviewed there were numerous instances in the progress notes where the name and/or designation of other staff members making an entry into the progress notes could not be identified. For example, in one file, there were seven entries over a one-week period in which either the surname and/or designation of the staff member making that entry could not be established. | The names and/or designations of all providers making entries into the resident record are not consistently identifiable. | The name and designation of the service provider making entries into the resident record is identifiable.  180 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Entries in the controlled drug register confirmed that two staff checked out any controlled medications. When a sample of four medication counts from the drug registered were compared with the quantity of medications stored in the controlled medication cabinet, the entries corresponded with the amount of medication available.  Up until four weeks prior to the audit, the required weekly checks of the controlled drug stocks and accurate entries had been recorded in the controlled drug register, but on the day of the audit it was four weeks since these checks had been completed. | The required weekly count/check of controlled medication stocks and the accuracy of entries in the register has not been completed consistently. | Weekly checks of the controlled drug stocks and the accuracy of entries in the controlled drug register are undertaken and documented.  7 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 | Food for the facility is procured from an established source, and the preparation of food complies with current legislation and guidelines.  The temperatures of the kitchen fridges/freezer were not recorded for 18 days in the month prior to the audit, or for the day immediately before the audit. Those temperatures that had been recorded were within the required temperature range. Leftover food items in the fridge were covered, and the date of preparation recorded (all had been prepared within the past 24 hours). Any opened food containers in the fridge had the date of first use documented.  Cleaning schedules had been developed which detailed daily, weekly and three-monthly cleaning requirements. The implementation records for those cleaning schedules were incomplete. For example, two items on the three-monthly schedules were at least two months overdue, while on the daily cleaning record the majority of cleaning tasks were recorded as having been completed. On observation, the kitchen was slightly untidy but relatively clean.  Dry goods are stored in two separate areas. Most dry goods had been placed in plastic containers once opened, but the date of first use of many items was not recorded or else only partially recorded (eg, day/month recorded, but not year). The cook advised these containers were not washed prior to being refilled. Two bags of sugar, and a bag of flour, had not been resealed after being opened.  The cook, who had only recently been appointed to the role, stated they were a qualified chef, and also had current food safety qualifications. This was verbally confirmed by the Facility Manager, and also the agency that had employed the cook immediately prior to their appointment at Ultimate Care Maupuia, but there was no documented evidence to confirm those qualifications. According to the facility’s education database, two other kitchen staff have completed food safety training. | Documentation related to the implementation of cleaning schedules is incomplete, as is the documentation related to daily temperature checks of kitchen fridges/freezers.  Dry food items do not have the date of first use recorded, and bags of dry goods were not resealed after being opened.  There was no confirmed evidence of the qualifications of the cook, including whether they had a current food safety qualification. | Cleaning schedules are fully implemented as scheduled. The checking of kitchen fridges/freezer temperatures is completed daily and documented. Any dry food items are appropriately stored after being opened, and the date of first use is recorded. There is documented evidence that all kitchen staff hold a current food safety qualification.  30 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.