# The Ultimate Care Group Limited - Ultimate Care Karadean

## 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 Karadean

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

**Dates of audit:** Start date: 11 June 2019 End date: 12 June 2019

**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:** 47

# 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** |
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|  | 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 Karadean Court provides rest home, residential disability and hospital level care for up to 53 residents. The service is operated by Ultimate Care Group and managed by a facility manager who has a dual role of clinical services manager. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family members, management, staff and a general practitioner.

This audit identified areas requiring improvement relating to open disclosure, adverse event reporting, staff training, assessments and care plans, medication management and infection data. Improvements have been made to the monitoring of residents’ weights addressing the area requiring improvement at the previous audit.

## 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. |

Open communication between staff, residents and families is promoted. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of some quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. Staffing levels and skill mix meet the changing needs of residents.

## Continuum of service delivery

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

The multidisciplinary team, including a registered nurse and general practitioner, 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. Residents are referred or transferred to other health services as required.

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

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

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## Safe and appropriate environment

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

There is a current building warrant of fitness.

## 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 organisation has implemented policies and procedures that support the minimisation of restraint. Two enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. No restraints were in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

Aged care specific infection surveillance is undertaken, 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.

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 10 | 0 | 3 | 3 | 0 | 0 |
| **Criteria** | 0 | 32 | 0 | 3 | 3 | 0 | 0 |

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| **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).

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| **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 | Ultimate Care Karadean Court’s complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers’ Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. There are additional forms available at the front entrance.  The complaints register reviewed showed that eight complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The facility manager (FM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There has been one complaint received from external sources since the previous audit. This is ongoing. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | Residents and family members stated they were usually kept well informed about any changes to their/their relative’s status, however, two family said they were not always informed about events at the time of occurrence. This was supported in residents’ records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Staff knew how to access interpreter services, although reported this was rarely required due to all residents being able 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 | Ultimate Care Group’s strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. There are Karadean Court specific goals included. The documents described annual and longer-term objectives and the associated operational plans. A sample of monthly reports to head office showed adequate information to monitor performance is reported including occupancy, staffing, financial performance, emerging risks and issues.  The service is managed by a FM who holds relevant qualifications and has been in the role for 11 months including as a registered nurse (RN). Prior to this she had been in a similar role for Ultimate Care Group at another facility. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The FM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing professional development.  The service holds contracts with Canterbury District Health Board (CDHB) for respite, complex medical conditions, rest home care, hospital level care and palliative care and Ministry of Health (MoH) for younger persons with a disability (YPD). On the first day of audit 47 residents were receiving services under the contracts, 44 under CDHB (15 rest home and 29 hospital residents) and three (YPD residents) under the MoH contract. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, and clinical incidents including infections and restraint minimisation.  The facility holds monthly meetings with staff and residents where some quality indicators are discussed. However, the scheduled quality improvement meetings have not occurred since January 2019. Staff reported their involvement in quality and risk management activities through audit activities and attendance at staff meetings. Quality graphs are displayed in the staff room to ensure staff are kept informed of trends. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed some issues with food, however since the survey in 2018, a new cook has been employed and feedback has since improved regarding food service. There were many positives in the survey including activities and care.  Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.  The FM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. |
| 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 document adverse and near miss events on an incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner (also refer to criterion 1.1.9.1). Adverse event data is collated and entered onto the organisation’s electronic system and a graph developed and returned to the facility for analysis and recommendations to be completed (refer criterion 1.2.3.6).  The FM described essential notification reporting requirements, including for pressure injuries. They advised there has been one notification of significant events 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 Moderate | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period, however annual appraisals have not been undertaken since 2017. A review of records and staff interviews confirmed that an initial induction and orientation programme is completed.  Continuing education is planned on an annual basis, including mandatory training requirements, however planned training has not occurred in 2019. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. Due to resignations, there is one registered nurse maintaining his annual competency requirements to undertake interRAI assessments (refer criterion 1.3.3.3). |
| 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 and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed.  The facility has had an influx of RN resignations for various reasons, leaving the facility short of the required RN cover when they had an increase of five admissions at about the same time. The CSM resigned her position in March 2019 and opted for an RN role leaving the CSM role vacant. At this time, there was a week when the facility was down in RN hours; however, agency cover has been utilised and the FM has covered some shifts. The FM introduced an extra caregiver shift and another weekend morning shift to provide additional caregiver hours. Agency staff were used and recruitment was implemented.  As of the 10th June the FM has assumed the dual role of FM and CSM. While the facility is still down in RN cover, they are using agency staff to cover for both RN and caregivers until full recruitment has been completed. One RN is due to commence on the Monday following the audit, with two others waiting final approval. The CSM role is advertised.  At the time of the audit staffing numbers meet minimum requirements. Care staff reported there are now adequate staff available to complete the work allocated to them. Residents and two family members interviewed supported this.  Observations and review of four weeks roster cycle confirmed adequate staff cover has now been provided, with agency staff used in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital. |
| 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 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. In files reviewed 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. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided monthly and on request.  Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. 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.  A review and report generated for the past month indicates pro re nata (PRN – as required) medications do not always include their effectiveness, and that a reason for medication omissions is not always documented.  There are two residents who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.  There is an implemented process for comprehensive analysis of any medication errors. |
| 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. | FA | The food service is provided on site by a 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 within the last two years. 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. The service operates with an approved food safety plan and registration issued by Waimakariri District Council. 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. Special equipment, to meet resident’s nutritional needs, is available.  Residents’ weights are regularly monitored to ensure they are stable meeting a previously required improvement.  Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| 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 care provided to residents was consistent with their needs, goals and care requirements. 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 good standard. Care staff confirmed that care was provided as outlined in the documentation (refer criterion 1.3.3.3). 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 provided by a trained diversional therapists holding the national Certificate in Diversional Therapy, an assistant and rostered 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 as part of the formal six-monthly care plan review.  Activities reflected 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 and satisfaction surveys. Residents interviewed confirmed they find the programme varied and interesting. |
| 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 six months in conjunction with the six-monthly interRAI reassessment, or as residents’ needs change. Examples of short-term care plans being reviewed and progress evaluated as clinically indicated were noted for two issues (refer criterion 1.3.3.3). When there are ongoing unresolved problems, long term care plans are added to at the time of re-assessment. Residents and families interviewed provided examples of involvement in evaluation of progress. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness (expiry date 20 June 2019) is publicly displayed. |
| 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. | PA Low | Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.  Monthly surveillance data is collated and entered into the organisation’s electronic system, graphs are produced and returned to the facility. However, analysis to identify any trends, possible causative factors and required actions is not occurring (refer criterion 1.2.3.6). Electronic data is benchmarked externally within the group. Benchmarking has provided assurance that infection rates in the facility are below average for the group.  The facility has had no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures and practice and her/his role and responsibilities.  On the day of audit, no residents were using restraints. Two residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. |

# 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 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Incident forms are completed at the time of the incident. There is a box to identify if and when the resident’s family member has been informed, however the sample of forms reviewed and interviews confirmed that this is not always completed and family are not always informed in a timely manner. | On the incident form there is a tick box to identify when/if family are informed, however this is often not completed, or the family are not informed until the next day. For example, six incident forms reviewed showed the event happening early evening (between 5pm and 7pm) and 10am Sunday and family were to be notified tomorrow / next working day. Four other forms did not have the applicable box ticked. Two family members interviewed reported that they were not informed until the next day after an event. | Residents and family members are informed of an event in a timely manner.  180 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | All incidents and accidents and other adverse events are reported and documented in the organisation’s electronic system. This excludes infections which have not been included for this year. The system develops a graph of all events and this is provided to the facility for analysis and recommendations to minimise events; however, analysis has not occurred.  Monthly meetings are held with staff, including kitchen staff, activities staff, registered nurses and household staff and residents to discuss issues specific to each area. Health and safety and restraint minimisation are discussed at these meetings, however other events such as complaints and adverse events are not included. The scheduled quality improvement meetings have not occurred since January 2019. | Adverse event reporting, complaints and infections are not routinely analysed and evaluated. Monthly quality improvement meetings are not occurring. | Quality improvement data is analysed and evaluated monthly and recommendations communicated to staff. Scheduled quality improvement meetings are held.  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 Moderate | The facility has had an influx of RN resignations for various reasons, including the resignation of the clinical services manager (CSM) along with three other RN’s in March 2019. The organisation provided some interim cover and agency staff have also been utilised, but because the service is rural not all RN’s want to travel. This has led to annual appraisals, training requirements and required competencies not being completed. As an RN, the FM has assumed the role of both FM and CSM until a replacement occurs. There are three RN replacements occurring in the next three weeks.  RN medication competencies have been completed and one RN is syringe driver (SD) competent (training for other RNs is due to occur on Monday 17th June). The SD competent RN is coming in to manage the one resident with a syringe driver in off duty time. | Three-month appraisals for new employees have been completed, however annual appraisals have not been undertaken since December 2017.  There is one end of life/palliative care resident with a syringe driver in place, however there is only one SD competent RN who is coming in to manage the resident in off duty time.  Not all care staff competencies have been completed in the past year (e.g., insulin and manual handling competencies have not been undertaken for those that are due in 2019). The 2019 planned in-service training for staff has not occurred. | The system to identify, plan and implement ongoing training and education for all staff occurs according to requirements.  60 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 | An electronic medication management system is in place and staff were observed to manage medicines safely. Medications were stored securely, and appropriate checks were occurring.  A review and report generated from the electronic medication management system for the past month showed that at least 10 PRN medications do not have a comment on the effectiveness of the medication and that there are many (over 100) medication omissions without comment as to why this has occurred. | There were two overdue GP medication reviews in the sample of 10 files reviewed.  The reason for medication omissions is not always included or the effectiveness of PRN medications. | Medicines management includes documentation of omissions, effectiveness of PRN medications and ensures three monthly GP reviews are occurring.  60 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | In files reviewed and as reported by the RN, on admission, an initial interRAI assessment occurs and a care plan is developed.  Long term care plans are developed and mostly reflected interRAI assessments. Paper assessment tools are used for interim issues, such as decreased mobility, falls and changes in care, but these are not always added to care plans, or a short-term care plan developed. For example, a resident who fell and has pain has not had interventions for management included in a short-term care plan or added to her long-term care plan. Her mobility and continence changes are also not included in care plan documents. The detail of the change in care and required interventions are documented in progress notes.  InterRAI assessments due from January 2019 to May 2019 have not been completed. Interim issues/assessments, such as pain, are not always included in the care plan or reviewed for effectiveness. | Eight interRAI assessments are overdue.  Review of care and evaluations are occurring but the findings from these are not always documented in care plans or a short-term care plan developed.  Care plans are not always updated, or short-term care plans developed when issues arise.  Pain assessments are not routinely completed, and effectiveness of treatment not always documented. | Assessments and care planning interventions are documented and reviewed to reflect the needs of residents within a timely manner.  30 days |
| Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | PA Low | Infection data is collected on a monthly basis and treatment for infections occurs, however this has not recently (since January 2019) been entered onto the organisations electronic data system so an analysis of infections occurs. | Monthly infection data is not entered on the electronic system so an analysis of infections can occur (refer criterion 1.2.3.6). | Ensure analysis of data is collated and analysed so the results of surveillance and specific recommendations are implemented to minimise infections.  90 days |

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

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

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

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

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| No data to display |

End of the report.