Melody Enterprises Limited - Ultimate Care Rhapsody

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.

The specifics of this audit included:

Legal entity:	Melody Enterprises Limited
Premises audited:	Ultimate Care Rhapsody
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 August 2017 End date: 30 August 2017

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: 67

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Ultimate Care Rhapsody provides rest home and hospital level care for up to 70 residents. The service is operated by the Ultimate Care Group and managed by a facility manager and a clinical services manager. Currently there is an acting facility manager in place while the recruitment process for a new facility manager is completed. 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 has resulted in the previous continuous improvement rating in the activities programme remaining in place and identified areas requiring improvement relating to risk management, medicine management and service interventions.

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 was confirmed to be effective. There is access to interpreting services if required.

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

Organisational management

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 acting facility manager, who is experienced in the aged care sector, currently manages the facility.

The quality and risk management system includes collection and analysis of 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 documented. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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.

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

The planned activity programme, provided by a diversional therapist and a recreational officer, provides residents with a comprehensive variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medications are administered by registered nurses and healthcare assistants all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. 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 overall 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.		Standards applicable to this service fully attained.

There is a current building warrant of fitness.

Restraint minimisation and safe practice

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. One enabler and four restraints were in use at the time of audit.

Infection prevention and control

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.

Aged care specific infection surveillance is undertaken, data is analysed, trended, benchmarked and results are 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	13	0	0	3	0	0
Criteria	1	35	0	0	3	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

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. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Additional forms are available on request and in the reception area. The complaints register reviewed showed that 20 complaints have been received to date this year, and that actions taken, through to an agreed resolution, are documented and completed within the required timeframes. There has been a reduction in the number of complaints being received over the past few months. Action plans show any required follow up and improvements have been made where possible. The facility manager 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 have been no complaints received from external sources since the previous audit.
Standard 1.1.9: Communication Service providers communicate effectively with	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, with the exception of one incident (refer 1.1.3), and outcomes of regular and any urgent medical reviews. 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.

consumers and provide an environment conducive to effective communication.		
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 strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to the national office showed adequate information to monitor performance is reported including financial performance, occupancy, emerging risks and issues. The service is being managed at present by an acting facility manager who has relevant experience and has delegated responsibility for finances and the day to day operations. He reports he is receiving support both for service issues and reporting requirements from head office personnel in the interim period until the new manager takes up the role. An appointment has been made and a new manager is expected to take up the role within the next two months. The acting manager confirms knowledge of the sector and relevant regulatory and reporting requirements. The service holds contracts with DHB and the MoH for aged related residential care, respite, short term rehabilitation, long term chronic health conditions, palliative care and YPD (younger persons with a disability) – residential non-aged care. 67 residents were receiving services under the contracts (18 hospital; 48 rest home level; and one MoH resident) at the time of audit. All beds are also designated as dual purpose.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Moderate	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes, and clinical incidents including infections and falls. Meeting minutes reviewed confirmed regular review and analysis of quality indicators both at a facility level and benchmarked at a national level. Related information is reported and discussed at the quality team meetings and clinical meetings. Staff reported their involvement in quality and risk management activities through both internal audit activity and the regular staff meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. Regular resident meetings are also held monthly and minutes reviewed showed a recent issue was raised and blinds were requested to manage sun in the dining areas. These were fitted very promptly. 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 acting facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. A number of concerns had been raised recently with the national office around clinical risk by both the facility manager and the clinical services manager; however, support has not yet been provided to assist in addressing the issues. 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 accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, and relevant action plans developed and implemented. A one off incident report noted in 1.3.12 has been addressed and closed off. Adverse event data is collated, analysed and reported on the national electronic system which then generates reports from the data and this is then used as part of the quality improvement planning process. The facility manager described essential notification reporting requirements, including for pressure injuries. They advised there has been one notification of a significant event made to the DHB since the previous audit. This was precautionary, and subsequently did not require any further action.
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	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. A comprehensive staff orientation package 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. Continuing education is planned on an annual basis, including mandatory training requirements. Care staff are required to complete a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Management are working with staff to ensure all in-service training is completed as required. Non-attendance is documented and further sessions provided for those who did not attend. A staff member is training to be the internal assessor for the programme and an external assessor is being contracted in to

		cover until the training has been completed. There are sufficient trained registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Additional training around medication management and assessment data when contacting the GP is also being implemented to address issues previously identified around RN performance. Records reviewed demonstrated completion of the required training and completion of annual 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 and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. 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. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a two-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage.
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 a manual system was observed on the day of audit, with the exception of some aspects of reconciliation, storage and review. 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 assessed as competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. Clinical pharmacist input is provided as requested. 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 temperature for the medicine fridge in the hospital 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 reviews were consistently recorded on the medicine charts. There were two residents self-administering medications at the time of audit, however the required documentation

		had not been updated. 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. Standing orders are not used.
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 in March 2017. 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 cook 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 were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. Evidence of overall resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	Resident and family interviews verbalised satisfaction with the care provided at Ultimate Care Rhapsody, however documentation, observations and interviews verified the provision of care provided to residents was at times inconsistent with their needs, goals and the plan of care (refer 1.3.3). The GP interviewed, verified that medical input is sought in a timely manner. 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.	FA	Activities are provided by a diversional therapist and experienced activities co-ordinator. Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that promotes quality of life through the provision of varied physical and mental opportunities that are meaningful to the resident. The programme is planned in consultation with residents, their advocates, family/whānau, nursing personnel and management, with the goal being to support residents past interests, relationships and participation in the community. Numerous ideas and activities suggested by residents are included in the programme, and the residents assist in the event planning, monitoring and review of ongoing activities. Family/whānau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate. A residents' meeting is held monthly. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that residents' suggestions and involvement is an integral part of the programme that is offered. The previous recognition of responding to residents' requests and implementing initiatives requested by residents remains in place. Interviews verified feedback is sought and satisfaction with the activities offered assessed.
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. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care, however early detection of potential problems before they occur was not evident (refer comments in 1.3.3.3 and corrective action 1.3.6.1). Short term care plans were consistently reviewed and progress evaluated as clinically indicated. 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 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit	FA	A current building warrant of fitness (expiry date 21 January 2018) is publicly displayed.

for their purpose.		
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 and management of the infection is documented in the residents' clinical records and on infection reporting forms. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The infection control nurse reviews all reported infections. A gastroenteritis outbreak in May, with four residents being unwell, entailed prompt isolation processes being implemented with the DHB and public health notified. The outbreak was quickly contained with no causative agent found. All staff were informed on the company's staff illness policy and staying away from work. Monthly surveillance data is collated and recorded electronically, and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality meetings, staff meetings and at resident handovers as confirmed in meeting minutes sighted and interviews with staff. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the CSM, FM, quality and staff meetings. Data is benchmarked internally within the group and externally with other similar organisations.
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 role and responsibilities. On the day of audit, four residents were using restraints and one resident was using an enabler, 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. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff. There has been a significant reduction in restraint use with 12 having been in use in March and only four at the time of this audit. There is a plan in place to work towards a completely restraint free facility as soon as possible.

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status	PA Moderate	The risk register had been updated in May to include some issues identified with clinical risks following concerns over performance of some of the RNs. A number of concerns had been documented and discussed at management level. However, there had been some shortfalls noted in the implementation of the required interventions in response to these. In May, and again in July, emails to the national office were sighted that raised a number of issues, with requests for some support made. This was confirmed by the clinical serves manager in interview. While there had been attempts to provide support, due to transport issues with weather related events and various other issues, this has not yet occurred. The clinical services manager and the facility manager were aware of the risks that had been identified and they were actively monitoring and working with the staff to address these. They did acknowledge there was still a need for additional support to	Risks around the clinical performance of RNs at the facility have been identified through the incident and accident reporting process over the past few months, both at facility and at national level. No comprehensive risk mitigation	Develop and implement a plan to address the clinical risks that have been identified at the facility. 30 days

of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.		ensure these risks were minimised. Refer corrective action for 1.3.6.1 for further information and clarification.	plan has yet been developed and implemented to address these issues.	
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	Medicines are supplied to the facility in a pre-packaged format, however there is no evidence of reconciliation, nor evidence of a systematic approach to ensuring stock medications have not expired. Supplies of some oral sprays were noted to be out of date. The records of temperature monitoring of the medicine fridge in the hospital wing was within the recommended range, however there was no evidence to verify the temperatures of medicine fridge in the rest home was being taken. A large build-up of ice was evident around the ice box. Two residents in the rest home self-administer inhalers. Documentation verifying the residents competence to self-administer inhalers is in place, however, it has not been reviewed within the last year. A change in a residents medication, on discharge, following an admission to an acute facility was not detected when the resident returned to the facility. The change in medication was recorded on the discharge summary, however this was not picked up, and alerted to on the medication chart. The medication continued to be dispensed, despite a query from the resident. The medication chart was updated by the GP, on the next visit. A family member informed the CSM. Interview with the CSM verifies the incident and corrective actions taken around the incident, however no incident form was sighted, nor the required processes required to identify minimising future risk. Medication management has been identified by the CSM as an area of high risk and training processes are in place to manage this. An electronic medication management system is being implemented next month.	Not all aspects of medication management complies with legislation and current guidelines, specifically around reconciliation, storage, disposal and self-administration of medications	Ensure all aspects of medication management comply with current legislation and guidelines 30 days

Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Residents and families interviewed expressed satisfaction with the care provided at Ultimate Care Rhapsody. However, a review of six files, observations and interviews verified the provision of care was at times not consistent with five of the six residents' needs (refer 1.3.3). Nursing management of resident's specific nursing needs and medical conditions was not well documented with minimal evidence of systematic planning and monitoring, to enable early detection of impending deterioration i.e. a resident requiring monitoring to identify potential deterioration before it presented, had periods when there was no monitoring, a resident at low risk for PI, had no documentation when risk increased. Interventions at time were not attended to within the required timeframes i.e. dressings noted to have not been attended to as requested, resident not cared for in a timely manner. Interviews with the RN and team leader were unable to identify systems in place to monitor the care the residents received each day was consistent with their needs.	The provision of care at times is inconsistent with meeting residents' needs.	The care residents receive is consistent with meeting their needs. 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
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.	CI	A previous continuous improvement initiative remains in place. Residents request to start a worm farm, based on their experiences of having worm farms in the past, and its benefits for their gardens, remains in place. They are assisted to manage the ongoing needs of the worms, including the bottling of the urine. Families assist in providing residents with the ongoing food to feed the worms, bottles for bottling the worm waste and selling of the product. Resident’s requests to have a yearly fair is continuing. Planning includes identifying products and stalls to be included in the fair. Residents and families are making, purchasing and collecting items to be sold at the fair. Regular excursions to the local hospice shop provides access to items residents will put to good use. The local community is given opportunity to participate in the fair. Residents manage the stalls. A review of last year’s fair by residents has identified the fair was a big success and opportunities for improvement in planning for this year’s fair are being addressed. Residents’ requests to go ‘opportunity shop’ shopping has been	Quality initiatives were identified and implemented in response to an expressed interest by residents at a residents’ meeting. The initiatives included the involvement of residents in the planning, monitoring and review of these activities. A formal review of each initiative has identified residents’ increased pleasure, a sense of achievement, improved social interaction and improved satisfaction.

		implemented, with monthly visits to local opportunity shops to purchase items of interest and use. A resident who is committed to getting rid of plastic bags at supermarkets, collects a range of material items from the “opportunity outing” and makes bags that are available freely at the facility entrance. All residents and families interviewed expressed positive feedback to the facilities achievements in regards to the quality of the activities programme provided at Ultimate Care Rhapsody.	

End of the report.