

The Ultimate Care Group Limited - Ultimate Care Karadean

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

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: 3 October 2017 End date: 4 October 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:	39

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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 Karadean Court provides rest home and hospital level care for up to 53 residents. The service is operated by Ultimate Care Group and managed by a facility manager and a clinical services manager. Residents and families spoke positively about the care provided.

This certification 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, volunteers and a general practitioner.

This audit has resulted in one area identified as requiring improvement relating to residents' weights.

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.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services with residents are provided at the time of their admission and thereafter as required. Staff training on the Code is being provided.

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

A comprehensive Māori health plan and related policies are in place. There were no residents who identifies as Māori at the time of the audit; however, suitable systems are in place, including access to appropriate cultural support, that will enable support to be provided in a manner that respects Māori cultural values and beliefs.

There was no evidence of abuse, neglect or discrimination and staff understood the 'no tolerance' stance of the organisation. Professional boundaries are maintained.

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

The service is maintaining linkages with the community and to specialist health care providers. Visitors are welcome.

Informed consent processes for a range of different situations are documented and signed off in residents' files. Residents are given choices.

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.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the Ultimate Care Group, with specific reference to Ultimate Care Karadean Court. 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 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. 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.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

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.
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Information packages that describe the services provided and the admission process are available. Ultimate Care Karadean Court work with local Needs Assessment and Service Co-ordination Services, to ensure access to the facility is appropriate and efficiently managed.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. A range of assessment tools are used. Registered nurses are on duty 24 hours each day in the facility and are supported by caregivers, allied health staff and a general practitioner. Shift handovers guide continuity of care and the clinical services manager provides additional support to the team.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

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

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by both registered nurses and care staff, 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. The kitchen was well organised, clean and meets food safety standards. Staff have food safety qualifications. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

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

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.

The infection prevention and control programme is reviewed annually and related policies and procedures are signed off by the Clinical Advisory Panel of the Ultimate Care Group. A suitably qualified infection control nurse, who is currently receiving oversight from the clinical services manager, is responsible for implementation of the programme.

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

Aged care specific infection surveillance is undertaken, with evidence of reported infections being analysed for trends and the results being benchmarked with national organisational data. Results and recommended actions are reported through all levels of both the facility and the organisation. Relevant actions, such as additional education, are being undertaken when surveillance processes indicate the need.

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	44	0	0	1	0	0
Criteria	0	92	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

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 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Policies, procedures and processes around the service provider meeting their obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code) were reviewed. Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The managers and staff reported and demonstrated their familiarity with informed consent processes. A policy on informed consent includes the definition of informed consent and references a range of other documents which are relevant to the topic. On admission, each resident signs an informed consent form for care and treatment, and a permission to collect, store and release information form. Completed versions were sighted in all resident records reviewed. Likewise, a range of other signed and dated consent forms were on file, including resident's individual choice regarding resuscitation, treatment of serious illness, a generic training /procedure consent form and an influenza vaccination consenting form. Staff were observed gaining residents' verbal assent, or otherwise, for their participation in day to day routines such as activities and personal care and support. Residents confirmed staff ask their

		<p>permission before they do things. Organisational documentation describes processes to be followed when a person is deemed as medically unable to give informed consent themselves. Enduring power of attorney documentation was on file as applicable.</p> <p>Other than the documents described, there were no formalised advance directives sighted in the resident files reviewed. One person had a section of an advance care plan completed and signed. Staff are currently undertaking training on advance care planning.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given an information folder, which includes a copy of the Code. This includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service and examples of their involvement were discussed with the clinical services manager. A representative from the advocacy services has recently visited to provide staff training on the topic.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Service delivery records sighted confirmed that residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. Participation in these were evident during the audit. An Ultimate Care Karadean Court van facilitates residents' attendance on outings and at community events</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they feel welcome when they visit and comfortable in their dealings with staff.</p> <p>Community involvement was evident with volunteers providing one on one support to some clients and/or sharing specialist skills with residents. Two volunteers were interviewed and both confirmed that they were oriented and are always welcomed by management, staff and the residents.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make</p>	FA	<p>The complaints/concerns/issues 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.</p>

a complaint is understood, respected, and upheld.		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 required. 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 the Health and Disability Commissioner since the previous audit. All documents and information requested has been forwarded to the HDC and the FM is waiting for any further follow-up process or actions from the HDC.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The clinical services manager informed that residents and family members are informed about the Code and about how to make a complaint at the time of admission. A copy of the information pack that is provided to residents on admission included a brochure on the Code and advocacy services. Further brochures on the Code and advocacy services were at the front door and a copy of the Code of Rights poster in both English and te reo Māori was on display. A volunteer had had the Code explained to her and residents confirmed during interviews that they had had them explained to them.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Guidelines for privacy and dignity describe clear and specific behaviours expected of staff when supporting residents. These include examples of ways to ensure people's dignity is maintained, ways in which their privacy is maintained and note that people's religious and cultural values and beliefs will be respected. A privacy and dignity policy refers to the Privacy Act requirements for handling residents' personal information. The facility manager is the privacy officer and guidelines for this role are listed. A policy on elder abuse and neglect describes how staff will ensure that no resident is subjected to abuse or neglect. This includes definitions of both abuse and neglect and the process of reporting any suspected abuse or neglect. Residents and families confirmed that they are receiving services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed ensuring doors were closed, residents' information was kept in the nurses' station and private conversations were not heard in public areas. All residents have their own private room.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability	FA	The organisation has a Māori Health Plan, a Māori Health policy, Māori perspective on health, and cultural safety policy. The Māori Health Plan includes the three principles of Partnership, Participation and Protection and describes how the holistic view of Māori health is to be incorporated into the delivery of services. Contact details for a person from the local iwi, who is prepared to support any

needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.		resident who identifies as Māori and to assist staff if necessary, were sighted. The facility manager and the clinical services manager spoke of their awareness of the importance of family/whānau for all residents, especially those who identify as Māori, and of Māori health pathways. They also noted the preparedness of the Oxford community centre to provide additional support services for any resident who identifies as Māori. Staff undertake Māori cultural training every two years and two staff who identify with their Māori culture further assist colleagues with this. There are not currently any residents who identify as Māori at Ultimate Care Karadean Court.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>A recognition of individual beliefs and values policy describes the process of including each person's own values and beliefs into their care plan and doing this with family/whānau involved in the process, as per the resident's choice. Staff training about residents' rights includes supporting residents to achieve their values and beliefs and in assisting them to practice any cultural activities. There is one person from another country whose needs are being acknowledged and examples of how the needs of two previous residents from other nations were met were provided. Staff at Ultimate Care Karadean Court talked of the residents' cultural needs in relation to the fact that most of the residents have come from the surrounding rural community and most are known within the small town of Oxford.</p> <p>A volunteer coordinates a Bible Study Group each week, a pastoral worker is available to support residents and there are weekly interdenominational services in the communal lounge each week. The social profile that is completed for all residents on admission reflects individual values and beliefs and residents stated that these needs are being met at the level they are capable of pursuing them.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Examples of documentation that demonstrated the service provider's stance of having no tolerance for any discrimination, coercion, harassment, sexual, financial, or other exploitation were provided. Residents, family members and volunteers were clear that they had not seen any evidence of such behaviour. The clinical services manager informed of actions taken to ensure that staff relations with residents work well to reduce the likelihood of these behaviours. There was no evidence of such actions within the incident reports viewed in residents' files, or through the incident reporting system.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Ultimate Care Karadean Court provided examples of quality improvement initiatives that they have undertaken. The service encourages and promotes good practice through working cooperatively with external specialist services and allied health professionals, including a palliative nurse, a district nurse, wound care specialist, community dieticians, services for older people, and mental health services for older persons.</p>

		<p>Other examples of good practice observed during the audit included the excellence of the activities coordinator in delivering a varied and individualised resident-centred activity programme. Part of this is the result of making additional efforts to recognise the type of activities individuals were responding to and developing on this. Another example is a programme that has seen residents become more involved in the orientation of new residents and implementing a 'buddy' system to support this. A third example was the efforts made to reduce timeframes for staff to answer call bells.</p> <p>Staff reported how they are encouraged to take on additional education. They confirmed they are well supported by the registered nurses and managers and they are given explanations of why they need to do things certain ways, which is enabling them to increase their confidence and promotes their compliance with best practice. The clinical services manager informed she has an expectation of team work and that she has an open-door policy for caregivers to ask questions and check practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There are guidelines for communicating with residents, relatives and visitors which sets out expected behaviours of staff. The need for open disclosure and what this constitutes is also noted in policy documentation. Incident forms include checklists used to confirm when open disclosure with family/whānau has been completed. Residents and family members stated they are kept well informed about any changes to their/their relative's status, are advised in a timely manner about any incidents or accidents and the outcomes of reviews. This was supported in residents' records reviewed and confirmed in examples provided by two residents. Client records included evidence of resident/family input into the care planning process and a registered nurse noted that they are encouraged to telephone, rather than email, families unless this has been specifically requested.</p> <p>A language policy directs staff to speak English in front of residents / family / whānau and with them. Contact details of the interpreter services were on the wall of the nurses' station. The clinical services manager noted that in her memory they have only accessed interpreter services once. Although that resident is no longer at the facility the experience worked well, as by coincidence the interpreter was local.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the Ultimate Care Group with specific reference to Ultimate Care Karadean Court. The documents described annual and longer term objectives and the associated operational plans. A sample of monthly reports to the board of directors showed adequate information to monitor performance is reported including emerging risks and issues, staffing and bed occupancy.</p> <p>The service is managed by a facility manager (FM) who holds relevant qualifications and has been in the role for just under a year. Responsibilities and accountabilities are defined in a job description and</p>

		<p>individual employment agreement. The FM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending health sector meetings.</p> <p>The service holds contracts with the DHB, MoH for younger people with a disability (YPD), respite, palliative and complex medical conditions. Thirty-nine residents were receiving services under the DHB contract including one respite resident and three MoH YPD at the time of audit. In each service stream were 19 rest home residents and 20 hospital residents.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the FM is absent, the clinical services manager (CSM) carries out all the required duties under delegated authority, with additional support from head office. During absences of key clinical staff, the clinical management is overseen by another registered nurse who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>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, clinical incidents including infections and pressure injuries.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meeting, quality and risk team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and survey feedback, attendance at meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed average call bell response time was slower than expected. As a result, the facility completed staff training and completed audits on response times showing the times had reduced significantly. This was confirmed by residents and family.</p> <p>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 are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The FM described the processes for the identification, monitoring, review and reporting of risks and</p>

		development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to head office as they happen.</p> <p>The FM described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>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.</p> <p>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.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. 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. A staff member is the internal assessor for the programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or</p>	FA	<p>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. 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 four-week roster cycle confirmed adequate staff cover has</p>

experienced service providers.		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 (24//7) RN coverage in the hospital.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>A clinical records documentation policy is in place. The name, date of birth and National Health Index (NHI) number of residents were on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>The reception person organises records for archiving. Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. It was observed during the audit that staff took time to ensure that no personal or private resident information was on public display.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The clinical services manager explained that referrals into the service are received by fax or email from GPs, hospitals, and a local needs assessment and services coordination agency (NASC). Residents only enter the service once their required level of care has been assessed and confirmed by the local NASC service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager and/or the clinical services manager. They are also provided with a folder of written information about the service and the admission process. At times the service operates a waiting list for entry; however, this is not always required. New residents get to choose their room when this is possible.</p> <p>Two family members confirmed during interviews that they were satisfied with the level of information they were provided with at the time of admission and about the time staff spent with them to explain things. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit,</p>	FA	<p>Exits and transfers are managed in a planned and co-ordinated manner, with an escort when appropriate. Most discharges were reported as being of resident deaths. Respite discharges are less formal as those receiving respite care are people known to the service and who are generally scheduled to return. An entry and exit form is completed and the discharge is recorded in the resident's</p>

<p>discharge, or transfer from services.</p>		<p>progress notes.</p> <p>A predetermined set of records including the interRAI transfer form, at least 24 hours of progress notes, the latest GP notes when relevant, an admission form (or interRAI record) with demographic information and the interRAI care plan is collated to facilitate any transfer of residents to acute care services.</p> <p>There is open communication between all services, the resident and the family, which family members confirmed. All referrals and transfers are documented in the progress notes and examples of this having occurred were viewed. The clinical services manager noted that if a person is transferring to another facility that key staff will always accompany them and a personal handover will be provided as well as the required resident records.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Within the clinical procedures of the organisational documents, there is a suite of medication management related documents. These include the wider management of medicines, reconciliation of blister packaged medicines, administering injections, non-package pro-re-nata (PRN) medication records, standing orders and warfarin management. In addition to procedural guidelines, are medication competency assessment questions and model answers for staff members.</p> <p>The Medi-Map electronic system is used to enable safer medication management and administration recording. Routine medications are supplied by the pharmacy in blister pack form. The medications that are not pre-packaged are individually supplied for each resident.</p> <p>When delivered, medications are checked for accuracy against the medication chart and the delivery date is entered into Medi-Map by a registered nurse.</p> <p>The resident's GP reviews medication charts on admission and three monthly thereafter, or makes alterations as required. Pharmacy input is available on request.</p> <p>Controlled drugs are stored in accordance with regulations. Two staff (one RN) competent in medicines management, check, administer, and record accurately. Weekly and six monthly stock balances were evidenced in the register.</p> <p>All drugs are stored safely and methodically with no overdue stock. The temperature of the medication fridge is checked and recorded daily and was within the recommended range. There is a register of competent drug administrators and specimen signatures, both of which are renewed annually.</p> <p>There was one resident who was self-administering medications at the time of audit. Policies and procedures for this were followed with good documentation. Staff check when doing regular medication rounds and record on a signing sheet.</p>

		A medicine administration round was observed. Staff observed were familiar with medications used in the facility and were aware of procedures for adverse reactions.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	PA Moderate	<p>The food service is provided on site by a qualified cook and kitchen team and is in line with recognised nutritional guidelines for older people. The four-week rotating menu with winter and summer options that is used by the Ultimate Care Group facilities is also being used at Ultimate Care Karadean Court. Evidence of the menu having been reviewed by a dietitian was supplied.</p> <p>A nutritional assessment and a nutritional profile are completed for each resident on admission. Personal food preferences, any requirements for modified diets, or of food textures, and for assistance with feeding are identified through this process. The registered nurse is responsible for providing these records with the kitchen and updating these when a person's condition changes. Kitchen staff described the systems in place to demonstrate that residents' needs are met and how they liaise with the caregivers and the registered nurses to achieve this. According to the evidence available, adequate nutrition is available, and people who demonstrate weight loss are being seen by relevant health professionals; however the number of residents losing weight, or continuing to lose weight is unusually high and has been raised as a corrective action for further investigation.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service has kitchen check systems and cleaning schedules that are being meticulously completed each day. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. Fridge and freezer temperatures are also being monitored daily. The food services manager has undertaken a safe food handling qualification, with kitchen assistants also having completed relevant food handling training. Kitchen staff are familiarising themselves with the food safety planning process.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>A policy on resident screening and selection is available. The facility and clinical services managers informed that if a person is clearly unsuitable for this facility, do not fit the criteria for entry, or they do not believe they will be able to provide the required level of care, then they may decline entry. Options are reportedly provided to the enquirer or are discussed with the needs assessment service if this is relevant. The managers stated that this has happened and they have been open and honest. A declined entry form is completed and the situation included in management level reports.</p>
Standard 1.3.4: Assessment	FA	<p>Information is documented using an initial nursing assessment and validated nursing assessment tools, including those for pressure injury risk, falls risk, continence, nutrition and oral health. The information</p>

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.		obtained from these and from the interRAI assessment is used to inform care planning and contribute to goal development. A master list demonstrated that all residents have current interRAI assessments completed by one of four trained interRAI assessors on site. The sample of care plans reviewed had an integrated range of resident-related information. Information from other sources, such as relatives, medical records, a medical review and a social profile also contribute to care and support plans and activity plans including goal setting. Pain assessments are recorded into 'Medi-Map' and baseline recordings are taken in preparation for monthly reviews.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in care plans reviewed. A standard format that is extremely lengthy is currently in use. The clinical coach for the organisation described the process that is commencing with staff toolbox training to progressively introduce a new template as resident reviews fall due. An example of this version was sighted, is more stream-lined and focuses on the issues identified through assessment processes.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> <p>Short term care plans are being used with clearly written goals and interventions towards resolution of the identified concern. Two examples of previous short term care plan issues having been integrated into the long term care plan were sighted.</p> <p>The team reported that the focus of the service delivery plans for young people with disabilities is around support and lifestyle and this was evident in the one reviewed and in conversation with a volunteer, the diversional therapist and one such resident.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>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.</p> <p>During the GP interview, he verified that medical input is sought when required, noted the excellent palliative/end of life care provided at Ultimate Care Karadean Court and commented on the skills of the registered nurses with wound care and healing. Caregivers noted they have access to the service delivery plans and use these, information from staff handovers at shift changes and registered nurse</p>

		<p>advice to provide residents' care. Residents and family members consistently reported the dedication of staff and the excellent care and support provided.</p> <p>A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	FA	<p>One qualified diversional therapist who has a national certificate in diversional therapy leads the planned activities within Ultimate Care Karadean Court. Volunteers from the local community contribute by offering one on one support, especially for the young people with disabilities, and by sharing specialist skills. Two of the volunteers and the diversional therapist were interviewed during the audit.</p> <p>The activities programme is planned by the diversional therapist one month ahead and examples of these were sighted. The monthly plans demonstrated that optional activities varied from picking flowers, puzzles, exercises and skittles, horse training, walking groups, 'Men's Shed', library visits, entertainment groups, music sessions and quizzes, to mention a few. Thirteen options for outings during the month of October were scheduled in addition to the in-house activities.</p> <p>The diversional therapist completes an individual social profile for each resident within two weeks of admission and examples of these were in residents' files. Some information may be gleaned from the interRAI and care plan assessment processes. These social profiles help the therapist to ascertain residents' needs, interests, abilities and social requirements. Planned monthly activities match the skills, likes, dislikes and interests identified in assessment data. A personalised recreation activities form is developed at the same time as the social profile. Individualised activities records are completed daily and these are reviewed at least monthly. Resident's activity goals and needs are evaluated three monthly and as part of their formal six monthly care plan review.</p> <p>The activities programme is discussed at the minuted residents' and indicated residents' input is sought and responded to. Residents interviewed confirmed they find the programme has plenty of variety and is often 'loads of fun'. High levels of participation were evident during the audit, including of the young people with disabilities. Staff assured the auditor this was normal attendance levels and attributed this to the 'energy' of the diversional therapist.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>According to the clinical services manager, a primary nursing model is in place and the registered nurse responsible for specific residents liaises directly with the clinical services manager regarding the residents. There is an expectation that progress notes of residents are written for every resident on every shift and this was evidenced in the residents' files that were reviewed. Similarly, when evaluation, review and monitoring processes are undertaken any identified changes to the resident's service</p>

		<p>delivery plan is to be recorded and examples of such changes were sighted.</p> <p>Medical reviews are completed every three months and although some reviews had been delayed earlier in the year, the medical reviews in the files reviewed were all current. Six monthly multidisciplinary meetings involving the residents and family members, as they choose are occurring. Reviews from all disciplines involved in the person's care and support and from the primary nurse are occurring. These follow the reassessment of the resident's interRAI. Short term care plans are being reviewed every one to two days by the registered nurse on duty. Records for other monitoring processes, such as food and fluid charts and wounds, for example, are being consistently completed.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a regular GP who visits the service, residents may choose to use another and some have. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input.</p> <p>Copies of referrals were sighted in residents' files, including to dietitians, speech language therapists, podiatry, older persons' mental health services and wound specialist services. A domiciliary dental service is available; otherwise residents are taken to their private dentist, or to the hospital dental department in the city.</p> <p>The resident and the family are kept informed of the referral process, as verified during interviews and in progress note records and family communication recording sheets. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency by ambulance if the circumstances dictate.</p> <p>A physiotherapist comes in once a fortnight and sees every resident as soon as possible after admission and every six to twelve months thereafter. Records of these visits are now being integrated into allied health notes.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is a designated chemical handler who has completed the required Chemical Handling Approved Handler Training (HSNO). An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using</p>

service delivery.		this.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 20 June 2018) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes shared ensuites. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry or by family members if requested. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty to clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team. These staff have completed all relevant training, as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 20 April 1999. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 05 September 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the number of residents. Water storage containers are located around the complex, and there is a generator available upon request. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells, an improvement since the last resident survey.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and many have doors that open onto outside garden or small patio areas. Heating is provided by fixed electric heaters in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from the Ultimate Care Group's clinical advisory panel. The infection control programme is reviewed annually.</p> <p>An infection control nurse has overall responsibility for infection prevention and control, including infection surveillance activities. Infection control matters are reported monthly to registered nurse meetings, the infection control meetings and the quality and risk meetings. Infection control meetings have representation from throughout the facility, including the food services area, management and caregivers.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>A documented role description is available for an infection control nurse, who is responsible for implementation of the infection control programme. The clinical nurse manager informed she continues to oversee the infection control nurse who is a senior registered nurse but has only been in the role for two months. In a previous role elsewhere, she was an infection control nurse, an infection control auditor and a Gold Auditor for hand hygiene, therefore has the required skills and experience to complete the required tasks. The infection control nurse has been enrolled in further ongoing training and applied for the Nursing Council infection control 'boot camp'.</p>
<p>Standard 3.3: Policies and procedures</p>	FA	<p>There is an Infection control manual with sections on infection and management, infection control, quality and risk management, infection control staff and health practices, policies and procedures,</p>

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		waste management and public health fact sheets. These have been developed in consultation with infection prevention experts and comply with current recommended best practice. A master record of updates demonstrates that all documents were current.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The Ultimate Care Group has supported the enrolment of the infection control nurse into further advanced education. The infection control nurse has already commenced formal infection control training with staff. This has included the introduction of the 'five moments' handwashing programme, a specialist topic and laundry and sluice room practice. During interview the infection control nurse described incidental education of staff when she sees poor practice, and an example of this was sighted.
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	<p>There is a policy on the surveillance of infections and procedure for surveillance of infections. In addition, a strategic document on infection control governance provides the organisational context for infection prevention and control practice that includes the infection surveillance programme.</p> <p>Although the infection control coordinator will be responsible for infection surveillance going forward, the clinical services manager informed that she currently reviews reported infections in consultation with the infection control nurse, each month. Graphs are formulated to identify trends and comparisons of data are made with that of previous months and years; as well as with the organisation's (Ultimate Care Group) national data. Surveillance reports and conclusions from review of the data are being reported to monthly meetings, including quality and risk management meetings.</p> <p>Infections in the surveillance programme include those of the urinary tract, skin, eyes, mouth and respiratory system. Since the last audit, there have been no outbreaks, or incidence of multi-resistant organisms reported. Surveillance and infection prevention internal audits assist the service provider in planning education and related quality improvement processes, which was confirmed by the infection control nurse and in the related documents. The surveillance programme is appropriate to that recommended for long term care facilities.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>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.</p> <p>On the day of audit, no residents were using restraints and three 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.</p> <p>There have been no restraints in use since the last audit.</p>
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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)
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>PA</p> <p>Moderate</p>	<p>The menu meets the requirements for an aged care facility and suitable systems are in place for ensuring individual resident's nutritional needs are met. The organisation has identified that there is a problem and monitoring processes with monthly reviews of the weight of all residents is consistently occurring and percentages of weight loss identified. Suggested reasons for weight gain and loss are made within the monitoring processes and referrals are being made to dietitians and/or the GP when this becomes evident. Senior staff and the GP noted that many people have become increasingly frail, although the GP did comment on reviewing residents with weight loss.</p> <p>On day one of the audit an observation of what was happening in the dining room demonstrated that residents were not being encouraged to eat, for at least five residents it was assumed they did not want it if they had not eaten much and the plate was removed. One person was told they would not eat it because they never do. A caregiver feeding one person was doing many other tasks simultaneously,</p>	<p>Ongoing monitoring of residents' weight is occurring and dietary supplements are being used; however, there is an unexplained increase in the number of residents who are losing weight and requiring referral to the GP and/or dietitian.</p>	<p>Systems are reviewed and processes implemented to ensure residents' weights are maintained at a stable level.</p> <p>60 days</p>

		<p>the food was becoming increasingly cold and the intake was minimal before the person gave up. During a spot observation the following day a similar thing happened with this person and the caregiver, although two more caregivers were feeding residents. On two different occasions during the audit people were offered their meal or 'fortisip', indicating it was being considered a substitute, rather than a supplement.</p> <p>In the sample of seven residents' files that were reviewed, six had lost weight, although one of these people had gained some. A master list of residents' weights reviewed showed that between 50% and 60% of residents had some weight loss recorded, albeit some was minor, in each of the months from June to August.</p> <p>Because of the positive factors of nutritious food being provided, ongoing monitoring of residents' weights and interventions from health professionals when required, it was not possible during the audit to make direct causal links regarding the higher than expected number of residents losing weight in such a facility. A corrective action has been raised as further investigation is considered necessary in view of the data and information around weight loss that was provided and the actions observed in the dining room.</p>		
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.