# Metlifecare Limited - Metlifecare Somervale

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Metlifecare Limited

**Premises audited:** Metlifecare Somervale

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

**Dates of audit:** Start date: 19 March 2018 End date: 19 March 2018

**Proposed changes to current services (if any):** The bed numbers have not changed and remain at 69, offering either rest home and/or hospital level care beds. The facility has been awarded a Bay of Plenty District Health Board (BOPDHB) contract for Provision of Health of Older Persons service (HOP contract). This contact is for two beds and is a dedicated bed contract which is funded regardless of use of the beds.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 62

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
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|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Metlifecare Somervale provides rest home and hospital level care for up to 69 residents. The service is operated by Metlifecare Limited and managed by a care manager (RN) who reports to the village manager. There is a team of registered nurses who support the care manager.

A significant change to the service since the previous audit is the new contract for two dedicated Bay of Plenty District Health Board funded beds for the Provision of Health of Older Persons. This contact runs from March 2018 to August 2018. It does not change the capacity of the bed numbers.

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 including the clinical quality and risk manager from Metlifecare head office, staff, and a general practitioner.

This audit identified area one area requiring improvement relating to complaints management. There were no areas for improvement required in the previous audit.

## Consumer rights

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

The service demonstrates that it communicates effectively with its residents and their relatives in a timely and open manner. The service adheres to the practice of open disclosure where necessary. There are appropriate processes in place to access interpreting services when required.

An electronic complaints register is maintained with identified complaints resolved effectively.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

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 undertaken monthly in an effective manner. This process is undertaken and reported by the care manager.

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 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

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The processes for assessment, planning, provision, evaluation, review and exit are provided within time frames that safely meet the needs of the residents and contractual requirements.

All residents have interRAI assessments completed and individualised care plans related to this programme. When there are changes to the resident’s needs a short-term plan is developed and integrated into a long-term plan, as needed. All care plans are evaluated at least six monthly.

The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a four-week rotating menu which has been approved by a registered dietitian. Residents’ nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

## Safe and appropriate environment

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

There is a current building warrant of fitness.

## Restraint minimisation and safe practice

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

The organisation has implemented policies and procedures that support the minimisation of restraint. The facility was restraint free at the time of audit with no enablers and no restraints in use. Policy states the 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

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

Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, in a timely manner.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 15 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 1 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | 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. Family and resident interviews confirmed they know how to make a complaint.  The complaints register reviewed showed that one complaint was received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The care manager is responsible for complaints management along with appropriate staff members from head office. Follow up is clearly documented. Staff interviewed did not always follow the documented process for the management of complaints.  There have been no complaints received from external sources since the previous audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Family members stated they were kept well informed about any changes to their/their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Staff know how to access interpreter services, although reported this was rarely required due to staff knowing the residents well and able to provide interpretation, for example, simple verbal and sign language cues as and when needed. The care manager stated that all the residents admitted to the facility acknowledge English as their first language. |
| 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 described annual and longer term objectives and the associated operational plans. A sample of quarterly reports to the clinical executive committee, who take the information to the board of directors, showed adequate information to monitor performance is reported including financial performance, ‘what went well’, quality data, staffing, complaints, emerging risks and issues.  The service is managed by a care manager who is a registered nurse and who holds relevant qualifications. The care manager has been in the role for two years with Metlifecare and has many years’ experience in the same type of role with other age care providers. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The care manager reports to the village manager. Managers interviewed, including the organisation’s clinical quality and risk manager, confirmed their knowledge of the sector, regulatory and reporting requirements. Members of management maintain currency through attendance at relevant education both clinical and non-clinical. Metlifecare offer a four-module training session for managers which the care manager has completed.  The service holds contracts with the Bay of Plenty District Health Board for rest home and hospital level care. The service has four appointed dedicated beds, two beds are for Transitional Active Care (TAC contract) and two beds are for Provision of Health for the Older Person (HOP contract). These four beds were occupied at the time of audit with all four residents being hospital level care. There were 58 residents receiving services under the Age Related Residential Care contract (36 hospital level and 22 rest home level care) at the time of audit. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | 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, wounds, near misses and falls. The status of quality data recording results are reviewed by the organisation’s clinical quality and risk manager and quality improvements are documented and implemented accordingly.  Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meetings, quality and risk team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through implementation of corrective actions and audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. One example sighted (falls audit January 2018) showed that not all staff were completing a full post falls assessment to meet policy requirements. Additional education was put in place and the audit is to be repeated in April.  The resident and family satisfaction surveys are completed annually. The most recent survey (2017) showed that there was a 98% overall resident satisfaction with the care and services at Somervale. The published results from the satisfaction survey is made available to all residents and family members. One corrective action undertaken following the resident satisfaction survey has resulted in a review of the wording of the questions to ensure they are easier to understand. This related specifically to residents and families identifying they were not sure of the process if they wished to make a complaint. Management confirmed that complaints management is discussed as part of the entry process and that a copy of the process has been included in the resident agreement.  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.  Management interviews described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. Metlifecare share learnings from all facilities related to health and safety findings as identified in documentation sighted and confirmed by staff. |
| 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 electronically and this information is viewed by the care manager who ensures all actions have been taken. The organisation’s quality and risk manager also views each occurrence. The electronic system used ensures all actions are documented as the system used does not allow staff to move on to a new section of the form until all requirements are met. A sample of incidents reviewed showed these were fully 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, the board, management and staff. This was confirmed in meeting minutes sighted.  The care manager and clinical quality and risk manager described essential notification reporting requirements, including for pressure injuries. They advised there has been one notification of a significant events made to the Ministry of Health (Section 31) in May 2017 regarding a sensitive issue. All actions taken are clearly documented including family notification.  There have been no police investigations, coroner’s inquests, and issues-based audits since the previous audit. Public health notification was sighted for an outbreak in March 2018. |
| 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 six staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show 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. Somervale have a new training initiative in place which covers all mandatory education and training in one day. Additional education is identified on the annual calendar. The staff confirmed the mandatory training day covers all aspects of service. The care manager monitors staff attendance to ensure all staff complete this at least annually.  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. Two staff members are internal assessors for the programme. There are sufficient trained and competent registered nurses (four) 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. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staffing levels shown on rosters exceed the required number of staff as shown on the interRAI level of care report. This was confirmed in an electronic labour tracking review undertaken daily.  The facility adjusts staffing levels to meet the changing needs of residents. An afterhour 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-weeks rosters confirmed staffing numbers remain constant and that adequate staff cover has been provided, with staff replaced in any unplanned absence. All staff hold current first aid certificates and there is 24//7 RN coverage on both floors of the facility including night duty.  Two days a week an additional RN is on duty so that RNs with specific tasks can have dedicated time to meet the requirements of the portfolio they hold such as infection control or to attend family meetings and undertake doctors’ rounds uninterrupted or catch up on paper work. This was confirmed during interview and documented on rosters. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy was current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe electronic system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required.  Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted included the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was not recorded on six of 12 medicine charts reviewed; however, these reviews were evidenced as up to date in the GP paper-based records in the residents’ notes. There is one resident self-administering medications and appropriate processes were in place to ensure this was managed in a safe manner.  There is an implemented process for comprehensive analysis of any medication errors. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by a kitchen manager (away at time of audit), one of two cooks and kitchen staff, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The care manager interviewed stated that the kitchen manager is currently developing a food plan and is aware of the council requirements and deadline. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook interviewed has undertaken a safe food handling qualification.  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. All food is prepared and cooked on site and delivered to six kitchenettes each with an adjoining dining room, with the use of hot boxes.  Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and in residents’ meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the 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. The facility is supported by four GPs. One ‘house doctor’ interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is appropriate. 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 | The activities programme is provided by a diversional therapist and an assistant who is currently training to become a diversional therapist. The activities team support residents Monday to Friday from 8am to 4.30pm. After hours and in the weekends, staff have access to activities at all times and integrate daily living with activities while supporting residents.  A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated three monthly and as part of the formal six-monthly care plan review.  Activities for residents are specific to the needs and abilities of the people living there and care plans identify the resident’s individual diversional, motivational and recreational requirements over a 24-hour period. Families and residents interviewed confirmed they find the programme stimulating and interactive. |
| 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. Where progress is different from expected, the service responds by initiating changes to the plan of care and there is evidence of care plans updated as changes occur for the residents throughout the six residents’ files reviewed. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections. When necessary, and for unresolved problems, long term care plans are added to and updated. Families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness (expiry date 20 September 2018) is publicly displayed. As the care home is newly built the service also holds a Code Compliance Certificate which was issued on 19 January 2018. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities and includes infections of fungal/skin, eye, wound, upper and lower respiratory tract infection, diarrhoea/vomiting and urinary tract infections. The IPC coordinator/registered nurse (absent at time of audit) reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.  Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year and this is reported to the staff, care manager and organization. The facility benchmarks data for respiratory tract and urinary infections with the support of an external source with eight other facilities within the organisation.  The facility has had a total of 31 infections since October 2017 (18 of those 31 infections were related to a gastroenteritis outbreak). One resident has been identified with frequent infections due to co-morbidities and has since deceased. Three other residents’ files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required.  A summary report for a recent gastrointestinal infection outbreak in March 2018 where 18 residents and 17 staff were affected was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented. |
| 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 (care manager) 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 their role and responsibilities.  On the day of audit, the facility was restraint free with no residents using restraints or enablers. Policy states that enablers are the least restrictive and used voluntarily at the resident’s request. The restraint register showed that the last use of an enabler was in February 2016.  Restraint is used as a last resort when all alternatives have been explored. This was confirmed by staff during interview. Education records sighted in staff files showed that all staff had undertaken restraint/behaviour management education in October 2017. |

# 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 1.1.13.1  The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA Low | The documented policy and procedure for complaints management identifies a responsive and fair complaints process which complies with Right 10 of the Code.  Feedback forms which are used to record complaints are clearly visible at reception and are located in the information folders at the entrance of the facility and in all six dining/lounge areas. Resident and family interviews confirmed that the complaints process is included in information given upon admission and that they would be happy to make a complaint if required.  Staff interviews identified that not all staff are following the documented complaints process. Three caregivers verbalised the fact that if anyone wanted to make a complaint they would advise the registered nurse on duty. Registered nurses confirmed this but they do not always follow policy requirements in dealing with complaints.  Education related to complaints management occurred in October 2017. | Two registered nurses described a process they use for complaints management which does not follow the documented Metlifecare procedures. Whilst one complaint was clearly documented in the resident’s clinical file and showed the actions taken to manage the complaint, the correct form was not used and the care manager was unaware of the complaint.  Neither the two registered nurses nor three caregivers interviewed knew where to locate the feedback forms.  The relative who made the complaint was interviewed and said they were very happy with the service provided and that they had no concerns. | Provide evidence that all staff are aware of the correct complaints procedure and the location of the feedback forms.  60 days |

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

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

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

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

|  |
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| No data to display |

End of the report.