

Metlifecare Limited - Highlands Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Metlifecare Limited
Premises audited:	Highlands Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 August 2017 End date: 9 August 2017
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	37

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
Yellow	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
Red	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 Limited Highlands Hospital provides rest home and hospital level care for up to 40 residents. The service is operated by Metlifecare Limited and managed by a nurse manager who reports to the village manager. There is a village co-located with the care facility which is not included in this audit.

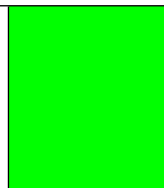
This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management and staff. A general practitioner was not available for interview on the day of audit.

This audit has resulted in seven areas identified for improvement relating to quality and risk management, adverse event reporting, staff education, service provision timeframes, care planning and activities.

The service has fully addressed improvements related to enquiry information, staff appraisals, and maintenance.

Consumer rights

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



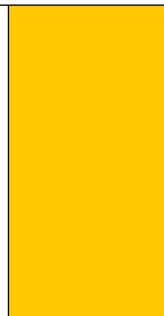
Standards applicable to this service fully attained.

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

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

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

Adverse events are documented. 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. Staff performance reviews are up to date. There is an annual training/education calendar in place which is organisational wide. Staffing levels and skill mix meet the changing needs of residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The organisation has systems and processes to assess, plan and evaluate the care needs of residents requiring hospital and rest home level care. Staff are qualified to perform their roles and deliver all aspects of service delivery. The residents' care plan format includes the needs, outcomes and/or goals. The organisation uses a mix of electronic and paper based assessment tools.

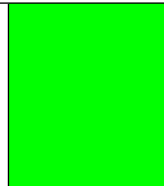
There is an activities plan.

A safe medication prescribing, administration and storage system was observed. The registered nursing staff have been assessed as competent to perform their role.

The menu plans have been reviewed by a dietitian. Each resident is assessed by the RN and clinical manager on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. The kitchen complies with current food safety legislation and guidelines.

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.

All areas of the building are maintained. There is a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support a restraint free environment. No enablers nor restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process is identified in policy and procedure should they be required. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken, and results are reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	11	0	4	2	0	0
Criteria	0	33	0	4	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that 10 complaints have been received over the past year and that actions taken, through to an agreed resolution, have been documented and completed within the timeframes. Action plans showed any required follow-up and improvements have been made where possible. The nurse manager is responsible for complaints management and follow-up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>One district health board (DHB) complaint was received in July 2016. A full investigation was completed by October 2016 and the complaint was closed following the recommendations being implemented by the service. These related to staff ongoing education and manual handling training. There were no open complaints at the time of audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>Residents and family/whānau reported they were kept well informed about any changes to their/their relative's status. However, this is not always documented as identified on incident and accident forms sighted. Refer comment in criterion 1.2.4.3.</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>Staff demonstrated knowledge of how to access interpreter services, although reported this was rarely required due to staff being able to provide interpretation as and when needed and the use of family members.</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>	<p>FA</p>	<p>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 monthly reports to the senior management committee at Metlifecare head office, who then report directly to the board of directors, showed adequate information to monitor performance is reported including financial performance, occupancy, quality data outcomes, complaints, behavioural issues, health and safety, resident weight loss, interRAI, staffing, emerging risks and issues. Quarterly reporting occurs against the business plan to show actions taken towards meeting identified goals.</p> <p>The care service is managed by a nurse manager who holds relevant qualifications and has been in the role for four months. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The overall management of the service is undertaken by the village manager who is experienced in the role. The facility manager was not on duty on the day of audit. The facility manager's staff file identifies that they have completed post graduate education and been in previous senior management roles for five years.</p> <p>The service holds contracts with the DHB for Long Term Support Chronic Health Conditions – Residential and Respite and Age Related Residential Care and Short Term Respite (Interim Care). One resident was receiving services under the interim care contract and 32 hospital and 4 rest home level care residents were receiving services under the Age Related Residential Care Contract.</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>	<p>PA Moderate</p>	<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, a regular patient satisfaction survey, monitoring of outcomes, health and safety, clinical incidents including infections and pressure injuries. Not all required actions are taken to maintain the documented requirements for quality and risk management. Internal audits are not up to date and corrective action planning is not always documented.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of key quality indicators such as event reporting, complaints, infection control, health and safety and restraint information, is reported and discussed at the senior management and staff meetings. Staff reported their understanding of quality and risk management activities and confirmed they are discussed at staff meetings.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey (July 2017)</p>

		<p>showed that the service gained an 86% overall satisfaction rating which has improved from 70% in 2016. The issues which gained the lowest ratings, such as complaints management and activities have been identified as opportunities for improvement. Corrective actions are yet to be put in place to show how improvement will occur.</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 were current. The document control system, which is managed from head office, ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The village manager 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. The Health and Safety Committee meeting minutes identify actions taken for all identified hazards. They also review the hazard register monthly.</p>
<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>	<p>PA Low</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed that incident forms are still not consistently completed. This was an area identified for improvement in the previous audit and remains open. Adverse event data is collated, analysed and reported to senior management and staff.</p> <p>The senior RN described essential notification reporting requirements, including for pressure injuries. Evidence of required reporting sighted. In May 2017 the service reported a stage 4 pressure injury to the Ministry of Health and in July 2017 an infectious outbreak was correctly notified.</p> <p>There have been no police investigations or coroner's inquests 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>	<p>PA Low</p>	<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 were being consistently implemented and records were 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, by head office. Additional, site specific education is added to the calendar. The education documented has not all</p>

		<p>been undertaken. Staff confirmed that since April 2017 very little ongoing education has occurred.</p> <p>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. Staff were concerned that they have not been able to continue with their studies in 2017. A staff member is the internal assessor for the programme. When discussed with the village manager and senior RN it was confirmed that tool box education is undertaken to address issues that occur and owing to staff shortages and a change of nurse manager the set programme has not been maintained.</p> <p>There are sufficient trained and competent registered nurses (2) who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed identify what training staff have completed. All staff records reviewed identified that annual performance appraisals were up to date. This was an area identified for improvement in the previous audit and has been fully addressed by the service.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</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. 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. Currently the facility has a high bureau staff usage but evidence was sighted that they are actively recruiting. This process was delayed owing to a recent infection outbreak (July-August 2017).</p> <p>With the exception of the activities coordinator role, which is currently vacant, observations and review of a four-week roster cycle confirmed adequate clinical staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage. (Refer comments in standard 1.3.7). The village manager confirmed the service has advertised for an activities coordinator as part of their recruitment drive.</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</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their family/whānau are encouraged to visit the facility prior to admission and are provided with written information about the service; this addresses the previous area for improvement at 1.3.1.4. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission.</p>

been identified.		
<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>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>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 on request.</p> <p>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.</p> <p>The records of temperatures for the medicine fridge and the medication room sampled were within the recommended range. There are no vaccines stored onsite.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines are met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no standing orders or residents who were self-administering their medications. There were appropriate processes in place to provide guidance on self-administration, should a resident be assessed as competent to perform this role.</p> <p>There is an implemented process for analysis of any medication errors, though this was not consistently evidenced (refer to 1.2.4)</p>
<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</p>	FA	<p>The food service is provided on site by the kitchen located in the retirement village. The menu has been reviewed by a dietitian to reflect recognised nutritional guidelines for older people. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident's nutritional needs was available.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the</p>

<p>delivery.</p>		<p>plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. The service has been implementing a project related to the serving of food, to create a homelier environment.</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>	<p>PA Low</p>	<p>The care staff interviewed and observations of care did reflect the needs of the residents are being met. Improvements are required in the level of detail and accuracy of the interventions in the care plans.</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>	<p>PA Low</p>	<p>The activities coordinator role was vacant at the time of audit. There are activities provided as part of the retirement village and assistance from the care staff. Three residents and two families commented that they felt most of the activities provided were not of interest to them. Two residents and a family did comment that the 'special events' such as birthday celebrations were of 'exceptional' quality.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Two of the residents' files sampled (with admission over six months) did not have an evaluation within the last six months (refer to the corrective action at 1.3.3.3). In the other files sampled the formal care plan evaluations did occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change.</p> <p>In five of the six files sampled, where progress was different from expected, the service responded by initiating changes to the plan of care (refer to corrective actions at 1.3.6.1). Short term care plans were noted for infections, wounds and challenging behaviours. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and family/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes and family meetings.</p>

<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>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 09 March 2018) is publicly displayed.</p> <p>The lounge area, doctors' clinic and bathrooms have all been refurbished. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. This was an area identified for improvement in the previous audit and is now fully met by the service.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover to ensure early intervention occurs.</p> <p>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 comparisons against previous years and this is reported to the facility and Metlifecare organisational management. Data is benchmarked externally within the group and other aged care providers.</p> <p>The infection log for a recent gastrointestinal infection outbreak was reviewed and demonstrated the appropriate transmission based precautions and reporting to public health/DHB. The samples that were sent to the diagnostic laboratory have not yet been confirmed.</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 education and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. Staff interviewed had a very good understanding of safe restraint use should it be required.</p> <p>Policy states that enablers are voluntary and the least restrictive option to meet the needs of residents with the intention of promoting or maintaining independence and safety.</p> <p>On the day of audit, no residents were using restraints and no residents were using enablers. The restraint register identifies the facility has been restraint free since 2015.</p>

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 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	PA Low	<p>The organisation has a clearly described quality and risk management system. Key components of quality data are collected and reviewed. Outcomes are shared with staff and senior management. Staff reported that the internal audit system and corrective action follow-up has not been maintained owing to a recent change in nurse manager. Senior staff who fill in for the nurse manager complete parts of the quality and risk requirements but they do not undertake internal audits, put corrective actions in place or enter required data into the electronic reporting system (V-care).</p>	<p>Not all aspects of the quality and risk management system is implemented.</p>	<p>Provide evidence that the organisational quality and risk management system is fully implemented by service providers.</p> <p>180 days</p>

<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Moderate</p>	<p>Corrective action planning was evident related to complaints management and internal audits up to April 2017. Most incident forms showed what actions are to be taken, such as short-term care planning is to be put in place. However, when one resident's file was reviewed, the short-term care plan had not been updated since May 2017. Refer comments in 1.3.3.3. Not all areas that require corrective actions are completed on the form. One example related to an incident which occurred on 4 August 2017 where the medication keys went missing. It is documented on an incident form but no corrective actions are documented. The senior RN was able to verbalise actions that were taken but nothing is documented.</p>	<p>Corrective action planning is not consistently undertaken.</p>	<p>Provide evidence that corrective action plans are put in place to address areas requiring improvement.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Low</p>	<p>Staff report all incidents and accidents using specific forms. Families confirm they are kept well informed. Refer comments in 1.1.9. The incident and accident forms sighted do not all indicate if the family have been informed and when a corrective action is required the information is not always shown on the form or converted onto a corrective action form. Refer comments in criterion 1.2.3.8.</p>	<p>Not all incident forms identify if family have been notified and not all opportunities for service improvement are documented.</p>	<p>Provide evidence that incident and accident forms are fully completed to meet policy requirements.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to</p>	<p>PA Low</p>	<p>The service has an ongoing educational calendar which identifies ongoing education for service providers. This covers all aspects of service delivery. The documented education was completed as per the calendar until April 2017. From April 2017 limited education has occurred and the documented education programme has not been followed. This is confirmed by staff during interview. Staff who are working through aged care educational papers have not been able to complete any papers in 2017. There is evidence that tool box educational</p>	<p>The education calendar in place is not followed by the service. Limited staff education has occurred</p>	<p>Provide evidence that organisational the education calendar is implemented by the</p>

provide safe and effective services to consumers.		sessions are presented at handover to address areas of concern.	since April 2017.	service. 180 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Moderate	<p>Staff demonstrated knowledge of individual resident care requirements but this was not well documented. Five of the six files sampled had shortfalls in meeting some aspect of time frames for assessment, evaluation and review. Two of the files sampled did not evidence the GP reviews being conducted monthly or three-monthly when assessed as stable. One recently admitted resident's file did not evidence an admission assessment or contain an interim care plan. Two files, of residents with admission over six months, did not have an evaluation conducted within the last six months. A review of the interRAI records evidenced that there are three assessments that are two weeks overdue for re-assessment. The organisation requires short term care plans to be evaluated at least monthly, this was not evidenced in one file.</p>	Five of the six residents' files sampled did not consistently meet the organisational and contractual requirements for assessments, planning, evaluation and review of the residents.	<p>Provide evidence that the timeframes for assessment, planning, GP reviews and evaluation of care meet organisational and contractual requirements.</p> 60 days
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	<p>The staff, resident and families reported that attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs. In the three files sampled using tracer methodology there was a difference between what was documented in the interventions required and what the assessed needs were. The resident admitted under the interim care contract had not had a care plan developed (admission within the past week). The progress notes and referral information did record the care interventions.</p> <p>Two hospital level of care residents and one rest home resident had inconsistent information in the care plans related to mobility, culture, vision and skin interventions (including one pressure injury). The families and residents did report overall satisfaction with the care provided, with some comments related to improvements in aspects of care and service that could be improved (such as the</p>	Four of the six files sampled did not have care plans that reflected the resident's current needs.	<p>Provide evidence that the care plan interventions are consistent with the needs of the residents.</p> 60 days

		cleaning of teeth and the laundry service).		
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>The service has a documented activities programme. However, as the activities coordinator role is currently vacant, (refer comments in 1.2.8.), at the time of audit it is only being partially implemented by care staff. There was limited documented evidence that planned activities were being provided in April and May 2017. No documentation was available from May to the date of audit. Interviews with residents and management confirmed activities were provided, though three of the four residents interviewed report that they only attended a 'couple of the activities' as most were not of interest to them. There was high praise for the special events that did occur, such as birthday and Christmas celebrations.</p> <p>The residents' files sampled did contain a social/diversional assessment and history undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. The resident's activity needs are evaluated six-monthly.</p> <p>The activities attendance sheets sampled in the resident's files did not record that there were activities conducted from 7 April 2017 to 30 May 2017.</p>	<p>Three of the five residents (and two of the five families) reported that the overall activities provided (apart from special celebrations), were not meaningful to the resident.</p>	<p>Provide evidence that activities are consistently meaningful to the residents.</p> <p>180 days</p>

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.