

# Metlifecare Limited - Highlands Hospital

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## 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:

<b>Legal entity:</b>	Metlifecare Limited
<b>Premises audited:</b>	Highlands Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 22 May 2018    End date: 22 May 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	40

# Executive summary of the audit

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## 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 Highlands Hospital provides rest home and hospital level care for up to 46 residents. The service is operated by Metlifecare Limited and managed by a nurse manager at the care facility and a village manager who has overall responsibility for the services offered. The nurse manager holds a current practising certificate and has been in the role for five months. The nurse manager has worked in aged care for 10 years.

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, staff, a physiotherapist and a general practitioner.

Areas requiring improvement at the previous audit were reviewed and showed that improvements have been made to quality and risk management implementation, corrective action planning processes, incident and accident management, care planning interventions, and activities. Two areas identified for improvement from the previous audit have yet to be fully addressed. These relate to staff education and resident care planning timeframes not being met. This audit has identified two additional areas requiring improvement related to food storage and incomplete staff orientation processes.

## 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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Open communication between staff, residents and families is promoted and 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.
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Business and quality and risk management plans include the scope, direction, goals, and values of the organisation. Monitoring of the services provided to the governing body is regular and effective. Both managers have been in aged care for 10 years. The nurse manager is a registered nurse moved into the current role five months ago. The nurse manager is supported by the village manager and the clinical, quality and risk manager as required.

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.

Policy identifies that the appointment, orientation and management of staff is based on current good practice. Ongoing education is undertaken by staff. Staffing levels and skill mix meet the changing needs of residents.

## Continuum of service delivery

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

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 seasonal 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

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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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.
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The organisation has policies and procedures that support the minimisation of restraint. At the time of audit there is one enabler and no restraints in use. Policy shows that a comprehensive assessment, approval and monitoring process with regular reviews occurs should restraint be used. 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

<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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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.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	1	2	0	0
Criteria	0	35	0	2	2	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 of Rights. 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 no complaints have been received since the previous audit. The nurse manager described actions that would be taken to resolve issues, was aware of the documentation required and the timeframes to be met. Complaints management includes the use of corrective actions to improve services as appropriate. For the care unit, 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. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents 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. Throughout the facility there are suggestion boxes with feedback forms to support compliments and complaints and this information is also provided in information packs to new residents and their families. The noticeboard in the residents' lounge/dining area provided contact details which identified the supporting advocate, telephone interpreting services and local iwi</p>



<p>provide an environment conducive to effective communication.</p>		<p>contact specific to the facility's local community. Each resident's bedroom door had a small sign that highlighted the primary nurse and caregivers that support the resident and each resident's room had a copy of the Code of Rights.</p> <p>Staff knew how to access interpreter services. There are currently two residents who do not speak and/or understand English. Family visit most days and interpret as required. Staff know the residents well, can also provide interpreting and have been provided with cue cards, white boards and pictures to support communication. There are no residents currently who affiliate with the Maori culture. There are two residents residing at the facility who have a significant sensory loss. Specialised equipment and community support services have been provided to encourage and maintain their independence and external support, for example the NZ Blind Institute and Hearing Association NZ.</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 describe annual and longer term objectives and the associated operational plans. A sample of quarterly reports against the set goals of Highlands Hospital, which match those of the organisation, showed adequate information to monitor performance is reported including financial performance, occupancy, quality indicators, emerging risks and issues.</p> <p>The clinical service is managed by a nurse manager who is a registered nurse with a current practising certificate. They maintain ongoing relevant education and have been in the role for five months. They have 10 years' experience in aged care. Change of management was notified to HealthCERT. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through both clinical and management training and education.</p> <p>The service holds an Age Related Residential Care (ARRC) contract with Counties Manukau District Health Board for respite, medical non-acute and hospital and rest home level care. At the time of audit all 40 residents (four rest home level care and 36 hospital level care) were receiving services under the ARRC contract.</p> <p>It was noted on audit that there are five apartments which have been approved for rest home level care. None of the apartments were being used for rest home level care at the time of audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	<p>FA</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, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, wounds, pressure injuries and falls. This was an area identified for improvement in the previous audit and is now fully attained by the service.</p> <p>Meeting minutes confirmed regular review and analysis of quality indicators and that related information is reported and discussed at facility level at the management team meetings, and staff meetings. At organisational level</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>reporting occurs electronically and is discussed at the monthly clinical quality and risk management team and to the board of trustees.</p> <p>Staff reported their involvement in quality and risk management activities through audit activities and the implementation of corrective actions with outcome reporting to the nurse manager. Relevant corrective actions are developed and implemented to address any shortfalls. This was an area identified for improvement in the previous audit and is now fully attained.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey, July 2017, showed there was a 93% overall satisfaction rating for services at Highlands Hospital. An area identified for improvement related to activities and this is being addressed by the service via corrective action planning.</p> <p>Policy reviews are managed at an organisational level and they 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 nurse manager and visiting clinical quality and risk 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 risk register sighted was current and includes a dangerous goods register.</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>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. All forms along with residents' file reviews, identified that family are notified of any adverse events. This was confirmed during resident and family interviews. This was an area identified for improvement in the previous audit and is now fully attained.</p> <p>Adverse event data is collated, analysed and reported to the nurse manager, entered onto an electronic system and reviewed by the quality and risk management group, of which the clinical nurse director is a member, and reported at board of trustee level as required.</p> <p>The nurse manager described essential notification reporting requirements, including for pressure injuries. They advised there had been one section 31 notification of a stage three pressure injury to the Ministry of Health in May 2017. There have been no police investigations, coroner's inquests, issues-based audits or any other notifications made 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 Moderate</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 identified that not all the organisation's policies are being consistently implemented. Whilst there is an education calendar in place, which is being followed, there is no documented system in place to identify if staff are attending required mandatory education, such as fire and restraint training. Education documentation was an area identified for improvement in the previous audit and remains open.</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. A casual staff member is the internal assessor for the programme.</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 show that not all documentation of orientation is fully completed and there is no evidence of the three-monthly reviews being undertaken. Annual staff appraisals were up to date.</p> <p>There are two registered nurses who are interRAI competent, one undertaking training and the manager has management access only. 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 experienced service providers.</p>	<p>FA</p>	<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. The rosters reviewed show that the staffing numbers match the level of care reported in the interRAI.</p> <p>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 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> <p>The nurse manager works five days a week, Monday to Friday 8.30am to 5pm and is on call. Cleaning, laundry and kitchen staff have dedicated hours. The activities coordinator works from 10 am to 4 pm five days a week.</p> <p>Kitchen staff are employed by the village along with the maintenance team and dedicated staff (including night porters) to respond to the emergency call bells from the village.</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>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 weekly.</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. The pharmacy is booked to complete a controlled drug audit in June 2018.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. The facility offers flu vaccines however all vaccines are provided by an external source and no vaccines are stored on site.</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 met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are used, were current and comply with guidelines.</p> <p>There were no residents who were self-administering medications at the time of audit.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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>	<p>PA Low</p>	<p>The food service is provided on site by a kitchen manager and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows seasonal patterns and provides alternative meal options and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>Aspects of food procurement, production, preparation, transportation, and delivery comply with current legislation and guidelines; however, not all food was stored and/or disposed of properly. The service has an approved food safety plan and evidence was sighted to show that the kitchen is awaiting a certificate to show registration from the city council. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p>

<p>delivery.</p>		<p>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 and a copy of the menu for the day is provided on the dining room tables.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meetings minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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>FA</p>	<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. The previous audit identified an area for improvement to ensure that interventions specific to the resident were reflected in care planning. This corrective action is now addressed, and records were available to demonstrate this. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is very good. 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.</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>FA</p>	<p>The activities programme is provided by an activities co-ordinator who has commenced training to become a diversional therapist. The activities programme is supported and overseen by an occupational therapist. The activities co-ordinator supports residents Monday to Friday from 10 am to 4 pm.</p> <p>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.</p> <p>The previous audit identified an area for improvement to ensure that activities provided were meaningful to residents. This corrective action is now addressed, and records were available to demonstrate that activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. A calendar is provided in each resident's room and on the main notice boards throughout the facility. All rest home and hospital level care residents are encouraged to come to the main lounge daily to partake in the different activities. Ten residents have been identified as preferring to stay in their rooms, and the activities co-ordinator interviewed stated that they are all visited daily, and one to one support offered. There are two residents that remain independent in regularly attending community activities. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and</p>

		satisfaction surveys. Residents interviewed confirmed they find the programme interactive.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<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.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change, however not all evaluations are up to date (see criterion 1.3.3.3). Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>	FA	<p>A current building warrant of fitness (expiry date 09 March 2019) was publicly displayed. All warrant of fitness checks have been completed and there has been no change to the footprint of the facility since the previous audit.</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>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infections, respiratory tract infections, skin, wound, eye, gastro enteritis and other infections. The acting infection prevention and control (IPC) coordinator/nurse manager 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.</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.</p> <p>The facility has had a total of 15 infections since October 2017. One resident has been identified with three of those 15 infections due to co-morbidities. The resident's file 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</p>

		a higher risk of infections and the interventions required. Data is benchmarked externally within the group. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	<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. Policy indicates that Metlifecare facilities will be restraint free if possible. 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 their role and responsibilities.</p> <p>On the day of audit, no residents were using restraints and one resident had requested an enabler. The restraint register allows an auditable process of restraint and enabler use to be undertaken.</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)
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	All new service providers are required to complete a documented programme which covers the essential components of the service provided. In the staff files reviewed it was identified that not all staff orientation processes had been signed off as completed and the three monthly post-employment performance reviews are not completed.	The orientation and induction process for new staff is not always completed. This includes no documentation of the three monthly post-employment performance reviews for staff. This was evident in four of eight files reviewed.	Provide evidence that all staff orientation and induction processes are completed and include the three monthly post-employment performance reviews.



				180 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>There is an annual training calendar in place which covers all aspects of service provision. The training calendar is fully implemented which was an issue identified for improvement in the previous audit. However, whilst staff are required to sign an attendance sheet, there is no system in place to identify which staff have undertaken mandatory trainings each year. For example, four of eight files did not show that staff had undertaken fire and emergency education or restraint education in the last twelve months. There is no record kept of individual staff education/training hours.</p>	<p>There are no processes in place to capture staff mandatory education attendance or the number of education/training hours attended by each staff member.</p>	<p>Provide evidence that processes capture required staff education details to meet policy requirements.</p> <p>90 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Low</p>	<p>Food procurement, production and preparation comply with current legislation and guidelines. The kitchen supervisor interviewed was aware of the guidelines. However, on the day of audit two fridges in the two care home kitchenettes had food that was not covered or dated, and food was observed to be old/expired. One fridge had an excessive range of temperatures between 2.9 and 24.1 degrees Celsius and one fridge temperature was not being recorded. Written communication as a result of three meetings at the beginning of 2018 have been sighted highlighting that the fridges require maintenance. Signs on the fridge doors stated that no food was to be placed in the fridges. At the time of audit both fridges had all food items disposed.</p>	<p>Two kitchenette fridges did not have food dated or labelled and contained food which looked expired and fridge temperatures were not documented and/or followed up when temperature recordings were outside the guidelines.</p>	<p>Provide evidence to ensure that all food safety requirements are met and comply with current legislation and guidelines.</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision</p>	<p>PA Moderate</p>	<p>All 10 residents have individual, detailed and resident specific initial care plans and long-term care plans. In reviewing residents' files, there were three long term care plans, two evaluations and three interRAI assessments overdue. One</p>	<p>Not all residents long-term care plans,</p>	<p>Provide evidence that all required</p>

<p>(assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>of the three residents requiring an up to date interRAI assessment is currently in an acute hospital setting, however all three residents' interRAI assessments were due on the 5th,9th and 29th of April 2018. The senior registered nurse (interRAI trained) is the interRAI champion and is soon to be supported by a roving registered nurse from the organisation to support the completion and ensure all interRAI assessments are up to date. The facility has one registered nurse who commenced their interRAI training on day of audit and a two further staff are booked for training in July. A third interRAI trained staff member has recently left the facility. The three residents with overdue long-term care plans had up to date interRAI assessments and two of the three residents had their long-term care plans evaluated last in July and October of 2017. Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and family members interviewed stated that they were very happy with the care provided.</p>	<p>evaluations and interRAI assessments have been updated to meet the required timeframes.</p>	<p>timeframes meet contractual requirements.  90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.