

The Ultimate Care Group Limited - Ultimate Care Aroha

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:	The Ultimate Care Group Limited
Premises audited:	Ultimate Care Aroha
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 13 September 2018 End date: 13 September 2018
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:	44

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

Ultimate Care Aroha provides rest home, dementia and hospital level care for up to 46 residents. The service is operated by the Ultimate Care Group and managed by a facility manager with support from a clinical services manager. The recent establishment of a regional clinical services manager position will also provide additional clinical support to the service. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, a palliative care nurse and a general practitioner.

This audit has resulted in areas requiring improvement relating to corrective action planning and documentation of interventions. Improvements have been made to complaints, staff education, activities, nutrition and the environment, addressing all areas requiring improvement at the previous audit.

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 low risk.
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The facility quality and risk management plan includes the goals and objectives, values and mission statement of the organisation and the current business plan. Monitoring of the services provided to the national governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

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

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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Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

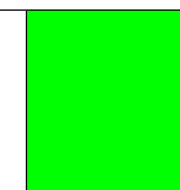
Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

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

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and senior care staff, all of whom have been assessed as competent to do so.

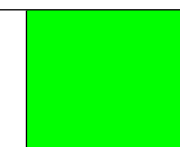
The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery and the service is provided by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

Safe and appropriate environment

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler is in use at the time of audit.

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, with data analysed, trended, benchmarked and results 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	14	0	1	1	0	0
Criteria	0	38	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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 seven complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and are all now completed within the required timeframes. Action plans showed any required follow up and improvements have been made where possible.</p> <p>The facility manager and the clinical services manager both take responsibility 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 provide an environment</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.</p> <p>Staff knew how to access interpreter services if necessary, although reported this was rarely required due to all current residents able to speak English.</p>

conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The quality and risk management plan, which includes the strategic direction and relevant business planning, is developed by the facility and reviewed annually by both the facility and the national organisation. This outlines the purpose, values, scope, direction and goals. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to the national office showed adequate information to monitor performance is reported including financial performance, emerging risks and issues and occupancy.</p> <p>The service is managed by a facility manager who holds relevant qualifications and has been in the role for one year. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirms knowledge of the sector, regulatory and reporting requirements and maintains currency with a current nursing practising certificate and regular attendance at sector events, seminars and meetings, both locally and nationally.</p> <p>The service holds contracts with the DHB for hospital (geriatric and medical), rest home, respite and dementia levels of care. Forty-four residents were receiving services under the contract (18 hospital, 11 rest home and 14 dementia) at the time of audit.</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>	PA Low	<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 residents satisfaction survey, monitoring of outcomes, clinical incidents including infections and medication errors.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the clinical, quality and risk team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and the regular meetings. Relevant corrective actions are developed and implemented to address any shortfalls in most areas, with the exception of the internal audits. Resident and family satisfaction surveys are completed annually, and two to three monthly residents' meetings are held and run by an independent advocate. The most recent residents' meeting minutes showed a request for a change in the timing of the 'happy hour', a concern with laundry efficiency and a request for more savoury items with their afternoon teas. All these concerns had been addressed immediately.</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 national document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The facility manager is familiar with the Health and Safety at Work Act</p>

		(2015) and has implemented requirements.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an 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. Adverse event data is collated, analysed and reported to the quality and risk committee as well as the national office. Collated and graphed reports are produced via the national electronic quality system for appropriate trend analysis and action by the facility.</p> <p>The clinical services manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health or other external agencies since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show 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. All staff are now completing the required core training. 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. Several staff members are internal assessors for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. There are sufficient trained and competent registered nurses (seven) who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
Standard 1.2.8: Service	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). The facility adjusts staffing levels to meet the

<p>Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>changing needs of residents using both national tools and assessed need levels of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of two week roster cycles confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence from a pool of casual staff. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</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 was 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. These medications are checked by a RN 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. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</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 electronic medicine chart.</p> <p>There were no residents who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this is able to be managed in a safe manner, when required.</p> <p>Medication errors are reported to the RN and clinical services manager (CSM) and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders can be used, as part of Ultimate Care's policy. When they are to be used, each individualised medication is authorised by the GP and dispensed as per the standing orders guidelines. No standing orders were in use at Ultimate Care Aroha at the time of audit.</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 delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a qualified chef 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. A food control plan is in place and was registered with the Ministry of Primary Industries on 27 June 2018.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</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. Special equipment, to meet resident's nutritional needs, is available.</p> <p>A resident-initiated request for cooked breakfasts has been responded to with cooked breakfasts being available every Tuesday morning. In addition, 'rolling breakfasts' are now available at Ultimate Care Aroha, with breakfasts available anytime between 0730 and 0930, to suit when the resident wakes up. The facility's goal is to move towards an environment that is homelier and more responsive to resident's needs.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. The dining room was spacious, with laundered tablecloths, tablemats and centrepieces on each table to enhance the dining experience for residents. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p> <p>A previous corrective action, around the availability of food at all times in the secure unit has been addressed. Evidence verified a wide range of food was always available in the secure unit.</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</p>	<p>PA Moderate</p>	<p>Documentation, observation and interviews verified the provision of care to residents was not always consistent with their needs, goals and the plan of care.</p> <p>A resident on Warfarin has appropriate documentation in place identifying the required interventions to monitor for the potential risks of being on the medication. The wound management strategies for residents with wounds were detailed and well documented. A resident who suffered a recent fall had a post falls assessment with comprehensive neurological assessment following the fall. Nine of fifteen files reviewed, however, did not accurately describe the required interventions to meet the residents' assessed needs.</p>

<p>desired outcomes.</p>		<p>Except for those areas mentioned in criterion 1.3.6.1, the attention to meeting a diverse range of resident's individualised needs was evident in other areas of service provision. An interview with a member of the "Sequel team", verifies Ultimate Care Aroha's commitment to providing quality palliative care. The team works alongside the staff to enable them to work in partnership with the hospice to support better palliative care in aged care. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs. Interviews with residents and families describe staff of Ultimate Care Aroha as "caring staff" who "accommodate each resident's needs". Staff are responsive to family's requests.</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 a trained diversional therapist, with the support of a recreation assistant and several volunteers. The programme at Ultimate Care Aroha is offered seven days a week.</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 regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted was diverse and matches the skills, likes, dislikes and interests identified in assessment data. The programme captures special themes and events and includes all residents. The ability of the programme to meet the needs of all residents with its diversity, recreation assistant and volunteers addresses a previous corrective action whereby the programme was limited by the resources available. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered.</p> <p>The activities programme includes all residents from each area. Examples included the 'beginning of spring', with lambs in the facility, camping (putting a tent up in the lounge under the residents' direction), a daily walking group, visiting entertainers, school groups, cultural groups, preschool groups (visiting and being visited), quiz sessions, weekly outings, a knitting group that knits blankets for the neonatal unit and daily news updates. The activities programme is discussed at the minuted residents and family meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs. A monthly newsletter goes out to all families and keeps everyone informed about what is going on.</p> <p>A twenty-four-hour activities plan guides the recreational activities to meet the twenty-four hour needs of residents in the secure unit.</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.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Apart from those examples referred to in criterion 1.3.6.1, where progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted of short term care plans being consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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 30 April 2019) is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and well maintained. The driveway has been repaired and is now being monitored for any further issues.</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, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The infection control nurse and CSM review all reported infections. 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 quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p> <p>No norovirus outbreaks have occurred at Ultimate Care Aroha in the last year.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, one resident was using an enabler, which was the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>The facility has an internal audit plan that is followed to review its internal operational and administrative processes. A review of the files evidenced these had been undertaken as per the schedule. However, where there had been partial attainments noted on some of the audits, this had not resulted in a corrective action plans with relevant actions to address any shortfalls noted. There was then no sign off by the responsible manager to reflect a monitoring process had occurred and the issue/s had been adequately addressed. A review of the past six months internal audits reflected a number of missing or incomplete corrective action plans. The corrective action planning for the other quality indicators recorded on the electronic quality system had been completed as required. Discussion with the facility manager and the clinical services manager confirmed that appropriate actions had in fact occurred, but they had not been recorded appropriately.</p>	<p>While internal audits are being regularly carried out as per the organisational schedule, formal corrective action plans are not being consistently developed when attainment is only partial. Where an action plan has been developed, there is no appropriate follow up and monitoring with managers sign off of any actions, once they have been implemented, to indicate improvements have been achieved and issues have been resolved satisfactorily.</p>	<p>Ensure all internal audits are reviewed consistently to identify any corrective action plans that need to be developed and these are completed as per the required process. Ensure all corrective action plans are then monitored and signed off by the relevant</p>

				manager. 180 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>	<p>PA Moderate</p>	<p>Seven of fifteen files reviewed, were of residents who had been identified as having challenging behaviours. All seven residents had behaviour assessments and behaviour monitoring in place. However, behaviour management plans identified the behaviours, though did not identify the specific individualised interventions required to manage those behaviours, or triggers to those behaviours. Behaviour monitoring charts verified challenging behaviour episodes remain. Interviews with staff verified the use of de-escalation strategies and staff were observed implementing these.</p> <p>Medication changes made by the GP to address one of the resident's behaviour, was not recorded in the care plan nor seen to be monitored for effectiveness. This was verified by staff interviews.</p> <p>A resident with weight-loss had a request by the GP to monitor the weight loss weekly and evidence is sighted of one weeks monitoring occurring, however no further weights were documented. Interviews with staff evidence no further monitoring has occurred. A GP note at the same consultation requests a follow-up in 2-3 weeks to ascertain possible causes. A review by the GP has not been followed up, with no system in place to capture the GPs' requests to follow-up residents.</p> <p>A resident with a history of congestive heart failure, has no documentation in place to alert staff to what interventions are required to monitor an early deterioration of the resident's health status.</p>	<p>The documentation detailing the provision of the required interventions to meet the resident's needs, is not consistent with the findings from assessment of the resident. This was evident in nine of fifteen files reviewed.</p>	<p>Provide evidence that the documented interventions in the resident's care plan is reflective of the resident's assessed needs</p> <p>90 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.