# The Ultimate Care Group Limited - Ultimate Care Rose Lodge

## 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 Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

**Legal entity:** The Ultimate Care Group Limited

**Premises audited:** Ultimate Care Rose Lodge

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

**Dates of audit:** Start date: 21 July 2020 End date: 22 July 2020

**Proposed changes to current services (if any):** Audit included review of reconfiguration to 29 dual purpose beds and one rest home level bed as per HealthCERT letter dated 4 December 2018.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 30

# 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.

## General overview of the audit

The Ultimate Care Group Limited - Ultimate Care Rose Lodge provides rest home and hospital level care for up to 30 residents. There were 30 residents at the facility on the first day of the audit.

This unannounced surveillance audit was conducted against the relevant Health and Disability Services Standards. The audit process included review of policies and procedures, review of resident and staff files, observations and interviews with residents, family members, management, staff and a general practitioner.

There were three areas requiring improvement from the previous audit, two have been closed out relating to service provider availability and planned activities. One previous requirement for improvement relating to service delivery plans remains open.

New areas identified as requiring improvement at this surveillance audit relate to complaint management, short term care plans, service delivery interventions, evaluations and medication management.

## Consumer rights

Information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is accessible to residents and families. Information is provided to residents on admission and available within the facility. Residents and family members confirmed their rights are being met; staff are respectful of their needs and communication is appropriate.

Open communication between staff, residents and families is promoted, and documentation confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

The nurse manager is responsible for managing complaints.

## Organisational management

The Ultimate Care Group Limited is the governing body responsible for the services provided at this facility. The mission, vision and values of the organisation are documented and communicated to all concerned.

The facility is managed by an appropriately qualified and experienced nurse manager who is supported by the regional manager. The nurse manager is new to the position and is responsible for the oversight of clinical service and the internal quality management programme.

The facility has implemented the Ultimate Care Group’s quality and risk management systems that includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Quality and risk performance is monitored through the organisations reporting systems. An internal audit programme is implemented.

Policies and procedures support service delivery, are current and align with good practice, legislation and guidelines. Monthly reports to the national support office allow for the monitoring of service delivery. The Ultimate Care Group Limited human resource policies and procedures are documented and implemented by Rose Lodge. Newly recruited staff undertake orientation appropriate to their role. Practising certificates for staff and contractors who require them, are validated annually.

Staffing levels within the facility are sufficient to meet the needs of the resident’s acuity needs.

## Continuum of service delivery

Registered nurses assess residents on admission within the required timeframes. The initial care plan guides care and service provision during the first three weeks after admission. The interRAI assessment is used to identify residents’ needs.

Long-term care plans are developed and implemented; these are individualised and based on a comprehensive and integrated range of clinical information. Residents’ files reviewed demonstrated their long-term needs, goals and outcomes are identified. Interviews confirmed residents are informed and involved in care planning. Shift handovers guide continuity of care and team work is encouraged.

The planned activity programme is managed by an activities coordinator. The programme provides all residents with a variety of individual and group activities and maintains their links with the community. A facility van is used for outings in the community. Family are able to participate in the activities programme.

Medication management is implemented using an electronic system. Medications are administered by registered nurses or health care assistants, 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. Kitchen staff have food safety qualifications. The kitchen meets food safety standards. A current food control plan is displayed and guides food service delivery. Residents and family confirmed satisfaction with meals.

## Safe and appropriate environment

A current building warrant of fitness is displayed. There have not been any alterations to the building since the last audit.

## Restraint minimisation and safe practice

The organisation’s policies and procedures support the minimisation of restraint. There were no enablers or restraints being used at the time of audit. Staff receive training at orientation and annually on restraint and enabler use, alternatives to restraint and managing challenging behaviours. Interviews confirmed understanding of the restraint and enabler processes. Enabler usage is voluntary. A restraint register is maintained.

## Infection prevention and control

Infection prevention and control surveillance is undertaken, analysed and trended. Results are reported to staff. Records showed follow-up action is taken as and when required. The infection control programme is reviewed annually. Staff interviewed demonstrated current knowledge and practice of infection control principles. Regular education in infection control is provided to all staff.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 12 | 0 | 1 | 4 | 0 | 0 |
| **Criteria** | 0 | 35 | 0 | 1 | 4 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | The nurse manager (NM) is responsible for complaints management. 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. The complaints forms are displayed and accessible within the facility. Staff interviewed confirmed their awareness of the complaints process.  The complaints register reviewed showed that two written and one verbal complaint have been recorded this year. Complaints documentation reviewed during the on-site audit evidenced not all relevant documentation was consistently available either electronically or stored in the hard copy complaints folder.  There are no complaints with external agencies. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their relative’s status and were advised in a timely manner about any accidents/incidents and outcomes of 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 Health and Disability Code of Health and Disability Services Commission rights (The Code).  Resident and family members reported that they are informed of resident’s meetings which are held monthly and that they attend as able. Review of meeting minutes evidenced information is shared such as verbal complaints and survey results and that there is an opportunity to provide feedback on services. The annual survey had been completed July 2020. Data was reviewed, with 10 of 17 surveys reporting Ultimate Care Rose Lodge (UC Rose Lodge) internal environment was cold (refer 1.3.6.1). The UC Rose Lodge newsletter is available to all residents and family members to keep them informed and relevant information is shared.  Staff interviewed demonstrated they know the process to access interpreter services when required. Interpreter services including sign language can be accessed via the district health board (DHB) or Interpreting New Zealand. There were no residents that did not speak English at the time of audit. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Ultimate Care Rose Lodge is part of the Ultimate Care Group (UC). The executive team provides support to the facility with the regional manager provided support during the on-site audit. The NM provides the executive management team with monthly progress against identified indicators. Ultimate Care Group has an overarching business plan and UC Rose Lodge has a business plan specific to the facility. The business plan includes reference to the proposed purchase of a new facility van (refer 1.3.7.1).  Posters observed at the entrance of the facility and information booklets available to residents, staff and family include the organisation’s mission statement, values and goals.  The service is managed by a NM who had been in the role for one day prior to audit. The regional manager was on-site providing orientation and support for the new manager. The NM is a New Zealand trained registered nurse (RN) with clinical and management experience in aged residential care for 17 years in Australia. Responsibilities and accountabilities are defined in a job description and individual employment agreement.  The facility can provide care for up to 30 residents, with 30 beds occupied at the audit. This included 29 dual purpose beds and one rest home level bed. Twenty three residents were at rest home level care, and seven were at hospital level care.  The facility contracts include hospital and rest home services, and palliative care services. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Ultimate Care Rose Lodge uses the UC quality and risk system that reflects the principles of continuous quality improvement.  Ultimate Care Group’s management team reviews all policies with input from relevant experts. Polices reviewed cover the necessary aspects of the service and contractual requirements, including reference to the interRAI long-term care facility assessment and processes. Policies include references to current best practice and legislation requirements. New and revised policies are presented to staff at staff meetings and policy updates are also provided as part of relevant in-service education. Staff interviewed confirmed that they are provided with new and revised policies and opportunity to read and understand the policy.  The documented control system ensures a systematic and regular process, including the approval, distribution, and removal of documents.  Service delivery is monitored through the organisation’s reporting systems this includes management of accidents/incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, falls medication errors, sentinel events, weight loss and wounds.  The internal audit programme is documented and implemented as scheduled. Internal audits cover all aspects of the service and are completed by the NM. Audit data is collected, collated and analysed. Where improvements are required following internal audits, corrective actions are developed. Results are reported on an electronic system which can be viewed by UC national support office. Interviewed staff reported that they are kept informed of audit activities and results at staff meetings.  Satisfaction surveys for residents and families are completed as part of the internal audit programme. A satisfaction survey had been completed two weeks prior to audit. Ten of the seventeen forms viewed at audit indicated resident dissatisfaction with the internal temperature of the facility (refer 1.3.6.1). During the on-site audit the regional manager alerted UC the internal environment temperature to enable a more temperate climate for residents once this is resolved. The 2019 collated and analysed survey did not indicate the same issue.  Facility meetings are conducted, for example general staff, quality improvement, activities and resident meetings monthly. Minutes of meetings evidenced communication with staff around aspects of quality improvement and risk management.  Clinical indicators are collated monthly and benchmarked against other UC facilities.  A review of the quality management data evidenced corrective actions plans were completed using the UC template when required with timeframes adhered to and evaluated as to the effectiveness of the plan.  Ultimate Care Rose Lodge has a risk management programme in place. Health and safety policies and procedures are documented along with hazard management programme. There was evidence of hazard identification forms completed when a hazard was identified and that hazards are addressed and risks minimised. The NM is the health and safety officer. A current hazard register was sighted on-site. Staff interviewed confirmed awareness of the process to report hazards. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff interviewed understood the adverse event reporting process in relation to their professional practice and regulatory requirements. They were also able to describe the importance of reporting near misses.  The NM and regional manager demonstrated in interviews they were aware of situations in which the service would need to report and notify statutory authorities including police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury, disease outbreaks and changes in key managers. Authorities have been notified of the new NM appointment.  Staff who witness an event or if first to respond to an event, document the adverse, unplanned or untoward incidents in the reviewed accident/incident forms.  Accident/incident forms evidenced family were contacted following any adverse event. The RN documents assessments of residents following an accident/incident. This includes neurological observations and falls assessments as appropriate. The NM signs off the accident/incident form. Results from accidents/incidents inform quality improvement processes and are discussed at facility meetings. Family interviewed confirmed they are notified when the resident has had an accident or a change in health status.  Policies and procedures comply with essential notification reporting, for example health and safety, human resources and infection control. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications, a position specific job description, signed employment contract and annual practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.  Professional qualifications are validated and there are systems in place to ensure that APCs and practitioners’ certificates are current. Current certificates were evidenced for all staff and contractors that require them.  Staff orientation includes all necessary components relevant to the role. Health care assistants (HCA) are paired with a senior HCA or RN until they demonstrate competency on specific tasks for example: hand hygiene, moving and handling. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and an annual performance review.  The organisation has a documented role specific mandatory annual education and training module/schedule. The mandatory continuing education included but not limited infection control, restraint/enabler use, moving and handling. Interviews confirmed that all staff, including RN’s undertake relevant education per year and that an appraisal schedule is in place. Staff education records evidenced the on-going training and education is completed. Two of the four RN’s were identified as interRAI competent.  Staff files reviewed show consistent documentation of annual performance reviews. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The organisation has a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, 7 days a week. The facility adjusts staffing levels to meet the changing needs of residents by using the casual work force and flexing the current roster.  Registered nurses interviewed stated there were adequate staff available to complete the workload and specific tasks allocated to them. Residents and family interviewed supported this.  Review of a four-week roster cycle confirmed staff cover is provided in line with the DHB contract, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate. Registered nurses are currently working 12 hour shifts to provide 24 hours, 7 days a week coverage. The facility has one full time RN vacancy and is currently advertising locally. Should the vacancy not be filled in a timely manner, a RN from another UC facility will be allocated.  The NM and/or a senior RN are on call after hours and weekends seven days a week.  The previous requirement for improvement to ensure adequate RN coverage to accommodate hospital level residents is now closed. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices in line with legislation, protocols and guidelines were observed. The required three-monthly reviews by the GP were recorded electronically. However, resident allergies were not consistently documented on the electronic medication chart.  The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. There are no standing orders used at the facility.  Review of the medication fridge evidenced that the service does not store or hold vaccines and interviews with the RN confirmed this. The medication refrigerator temperatures are monitored. However, the monitoring is inconsistent and does not comply with UC policy.  Medications are stored securely in accordance with requirements and where required are checked by two staff for accuracy in administration. However, weekly checks and six monthly stocktakes of drugs are not conducted in line with policy and legislation.  The staff observed administering medication demonstrated knowledge and had a clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures. The RNs oversee the use of all pro re nata (PRN) medicines and comments made regarding effectiveness on the electronic medication record sighted. Current medication competencies were evident in staff files.  There were no residents self-administering medication during the on-site audit. Appropriate processes are in place to ensure this is able to be managed in a safe manner, when required. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals are prepared on-site and served in the dining room or in the resident rooms if requested. The seasonal menu has been reviewed by a dietitian, with the winter menu implemented at the time of audit. Any deviation from the menu is recorded and the reason documented. The food control plan’s expiry date is August 2020. Current food management training and certificates for cooks and kitchen staff were sighted.  Food temperatures are monitored appropriately and recorded. The kitchen staff have relevant food hygiene and infection control training. The kitchen was clean and the cleaning schedules sighted.  A nutritional assessment is undertaken for each resident on admission by the RN to identify the residents’ dietary requirements and preferences. The dietary profiles are communicated to the kitchen staff and updated when a resident’s dietary needs change and when dietary profiles are reviewed six-monthly. Diets are modified as needed and the cook interviewed confirmed awareness of dietary needs and residents’ preferences. These are accommodated in daily meal planning.  Residents were seen to be given sufficient time to eat their meal and assistance was provided when necessary. There was sufficient staff to ensure appropriate assistance was available. Residents and families interviewed stated that they were satisfied with the meals provided.  All aspects of food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit comply with current legislation and guidelines. The cook is responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately in fridges, a freezer and cool store. Temperatures of fridges and the freezer are monitored and recorded daily. Dry food supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | The residents’ long-term care plans are completed by the RN and based on assessed needs, desired outcomes and goals of residents. Care planning includes specific interventions for long-term problems. All residents’ files sampled had individualised long-term care plans meeting the needs of the residents, however, short-term care plans are not consistently developed for all acute problems.  Interviews with residents and families confirmed that care and treatment met residents’ needs. Staff interviews confirmed they are familiar with the needs of all residents. Family communication is recorded in the residents’ files. The nursing progress notes and observations are maintained as per UC policy. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Long-term care plans are completed by the RN and based on assessed needs, desired outcomes and goals of residents. Care planning includes specific interventions for long-term problems. However short-term care plans are not in place for all short term problems (refer 1.3.5.2).  The GP interviewed, verified that medical input is sought in a timely manner; medical orders are followed; and care is of a high standard.  Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs. There was evidence of wound care products available at the facility. The review of wound care plans evidenced wounds are assessed in a timely manner and reviewed at appropriate intervals. Where wounds required additional specialist input, this was initiated.  Monthly observations such as weight and blood pressure are completed and are up to date.  The nursing progress notes are recorded and maintained. Family communication is recorded in the progress notes. Interviews with residents and families confirmed that care and treatment met residents’ needs.  The GP documentation and records reviewed were current. However, not all resident care interventions are documented in an integrated manner to guide resident care.  The facility corridors and the residents’ rooms all have night-storage heaters and there is a heat pump in the lounge. However, interventions noted to be in use throughout the audit included the use of hot water bottles to maintain resident comfort as a result of cold internal environmental temperatures, risking potential resident harm. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The residents’ activities programme is managed by an activities coordinator who is undertaking training to be a diversional therapist. Activities are provided 5 days a week, Monday to Friday from 11:00am to 4:30pm by the activities coordinator. Weekend activities are organised by the HCAs. Weekend activities include newspaper reading, bowls, quizzes and movies.  The activities programme provides activities for both hospital and rest home residents and is displayed on the residents’ noticeboards. A range of activities are planned which incorporate education, leisure, cultural and community events. The programme captures special themes and events and includes all residents. Van outings are scheduled each week. The van has no hoist to accommodate residents who use a wheelchair. However, purchase of a new van with hoist capability is in the facility’s current business plan. A church service is held once a month. The activities coordinator includes the hospital residents in planned activities and facilitates wheelchair walks outside for these residents when the weather permits. One on one time is scheduled for hospital residents.  The residents’ activities assessments are completed within three weeks of the residents’ admission to the facility. Information on residents’ interests, family and previous occupations is gathered during the interview with the resident and their family and documented.  There was evidence the activities coordinator is part of the InterRAI and care plan review process. The residents and their families reported satisfaction with the activities provided.  Over the course of the audit residents were observed engaging in a variety of activities.  The previous corrective action with regard to activities provided for hospital residents has been closed. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it is reported to the RN or clinical manager.  Formal evaluation of the long-term care plans occurs in conjunction with the interRAI re-assessments and if there is a change in the resident’s condition. Evaluations are documented by the RN. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Goals and interventions in the long-term care plans are updated to reflect changes identified by the evaluation process. However, evaluation of care plans is inconsistent and not always carried out within the required timeframes.  Wound management plans were evaluated each time the dressing was changed. However short-term care plans are not consistently developed or evaluated for other acute problems for example infections (refer 1.3.5.2).  Residents and families interviewed confirmed involvement in the evaluation process and any resulting changes. Contact with family was verified in the resident’s records and documented in the progress notes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is publicly displayed. There have not been any structural alterations to the building since the last audit. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The Ultimate Care Group surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal audits are completed. Surveillance data is collected in the clinical areas and collated monthly by the clinical manager for UC benchmarking.  The RN with responsibility for infection prevention and control has recently left the facility and it is planned that a recently employed RN will undertake the role.  Information following monthly infection data collection and benchmarking is provided to staff through quality and staff meetings and on the staff noticeboard.  New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Families are updated by phone, email or text if required. However, short-term care plans are not developed to guide care and evaluate treatment for all residents who have an infection (refer 1.3.5.2).  There was one outbreak in August 2019. Review of documentation evidenced this was managed and reported as required.  Two residents had been in precautionary isolation during the Covid-19 lockdown. Covid-19 information is available to all visitors to the facility. Ultimate Care information including Ministry of Health information was available on site. Infection prevention and control resources were available should a resident infection or outbreak occur. There is an antimicrobial use policy. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The new facility/clinical manager is the restraint coordinator and is intending to undertake training for this role. On the day of audit there were no residents using restraints or enablers. Restraint is used as the last resort after all other alternatives have been tried. Use of the enabler is voluntary. This was evident from documentation reviewed and staff interviews. The restraint register was sighted. Restraint minimisation and safe practice education is provided to all staff at orientation/induction to the service and ongoing education is provided to staff annually. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.13.1  The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA Low | Complaints policies and procedures guide staff through the process. A hard copy complaints register is in place and held in the complaints folder. A process to document all complaints in the electronic system was initiated in 2019. The electronic system lodges the date the complaint was received, category, actions taken and the date the complaint was resolved. However, records relating to each lodged complaint under investigation or closed; including correspondence to the complaint and/or investigation completed is not consistently held on file. | Not all information relating to each complaint is held in an integrated manner. | Ensure all documentation relating to complaints is held in an integrated manner and easily accessible.  180 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | All residents medication charts audited had been reviewed by the GP three-monthly; however, in five out of ten medication charts reviewed, medication allergies were not documented.  Medication is stored correctly and in line with legislation; however, the six-monthly pharmacy stocktake of medication was not carried out within the required timeframes.  Documentation of medication administration in the drug register was in line with legislation; however, weekly checks of the drug register were not carried out consistently.  Medications stored in the medication fridge were correctly labelled, however, the medication fridge temperature check was not carried out as per UC policy. | Not all medication practices meet policies, guidelines and legislation. | Ensure all medication practices meet policies, guidelines and legislation.  90 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | All residents had a long-term care plan which included interventions for long-term problems. However, in nine out of eleven files reviewed of residents who have had an infection; short-term care plans had not been developed to guide and evaluate care. | Care plans are not consistently developed to guide care for residents’ acute problems. | Ensure that short-term care plans are developed for all acute issues to guide care.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Residents are seen by their GP three monthly if stable and more frequently as needed. Six out of ten electronic medication charts reviewed evidenced care interventions documented by the GP. However, this information was not documented in the resident’s clinical record and was not accessible for staff to meet the changing needs of the resident.  There are night-storage heaters in all of the residents’ rooms and a heat pump in the lounge. During the on-site audit it was observed that residents were requesting and receiving hot water bottles. In the most recent resident survey (refer 1.1.9) a number of responses noted concerns related to lack of heating and feeling cold. All residents interviewed stated that the facility and particularly their rooms were cold. Residents also stated that at times they get out of bed in the night in order to move to a warmer communal area within the facility. Some residents were noted to be wearing gloves and scarves. | i) Not all resident care interventions are documented in an integrated manner.  ii) Current interventions to maintain resident comfort risk harm to residents. | i) Ensure all resident care interventions are documented in an integrated manner.  ii) Ensure interventions are in place to maintain residents’ comfort and safety.  60 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | Resident care is evaluated on each shift and reported in the progress notes and at handover. However, in two of five files reviewed formal evaluation had not been carried out within the required timeframe. | Formal evaluation of care plans is not consistently carried out within the required timeframes. | Ensure all care plans are evaluated six-monthly or more often if there is a change in the residents’ condition.  60 days |

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

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

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

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

|  |
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| No data to display |

End of the report.