

The Ultimate Care Group Limited - Ranburn

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:	Ranburn Rest Home & Hospital	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 2 February 2015	End date: 3 February 2015
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:	69	

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
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Ranburn Rest Home and Hospital provides residential care for up to 71 residents who require rest home, rest home dementia and hospital level care. The facility is operated by The Ultimate Care Group Limited.

This surveillance audit was conducted against the relevant Health and Disability Services Standards and the provider's contract with the District Health Board. The audit process included review of the policies and procedures, review of residents and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

This audit included a review of the eight aspects of service provision identified as requiring improvement from the previous certification audit, one of which has not been fully addressed and relates to resident documentation. There are areas requiring improvement from this audit relating to the currency of performance appraisals, the currency of competency assessments for restraint and aspects of safe food storage in the kitchen.

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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Staff demonstrated an understanding of residents' rights and obligations. This knowledge was incorporated into their daily work and caring for the residents. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family and complaints are investigated. Staff communicate with residents and family members following any incident.

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 Ultimate Care Group Limited is the governing body and is responsible for the service provided at Ranburn Rest Home and Hospital (Ranburn). A 'Management Plan' and a 'Quality and Risk Management Plan for Ranburn Lifecare' was reviewed and included a vision statement, values, quality objectives, quality and risk management plan, quality indicators and quality projects. Systems are in place for monitoring the service provided at Ranburn that includes regular monthly reporting by the facility manager to The Ultimate Care Group Head Office. The facility is being managed by a facility manager who started in this role in August 2014 and is supported by a clinical services manager/registered nurse who is responsible for oversight of clinical care. The improvement required from the last audit relating to the facility manager position has been addressed.

The Ultimate Care Group quality and risk management systems are in place at Ranburn Rest Home and Hospital. There was evidence that quality improvement data is collected, collated, analysed to identify trends and corrective actions plans are developed and implemented. There is an internal audit programme, risks are identified, and there is a hazard register. Adverse events are documented on accident/incident forms and there is an electronic database reviewed by personnel from The Ultimate Care Group Head Office.

There are policies and procedures on human resources management. All health professionals had current practising certificates. In-service education is provided for staff at least monthly. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards through the Aged Care Education (ACE) programme. Not all clinical staff have current restraint competency assessments nor current performance appraisals.

Review of staff records provided evidence that human resources processes were followed and individual education records maintained.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery, based on best practice. The minimum number of staff is provided during the night shift and consisted of one registered nurse and four caregivers. The facility manager, clinical services manager and the team leader are rostered on call after hours. All care staff interviewed reported there was adequate staff available and that they were able to get through their work. The improvement required from the last audit that related to the distribution of staff hours has been addressed.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Five areas identified for improvement in the previous audit have all been fully attained by the service.

All residents' files sighted from hospital, rest home and dementia care areas provide evidence that needs, goals and outcomes are identified and reviewed on a regular basis with the resident, and where appropriate their family/whanau. Resident and family/whanau members interviewed reported that they are satisfied with the services provided.

The assessment, provision of care and review of care is provided within timeframe to safely meet the needs of the residents. Improvements are required related to the documentation of evaluation of interventions at the time any changes are made. Services are coordinated in a manner that promotes a team approach and continuity of care. Care planning is based on assessment findings.

Planned activities provided reflect residents' strengths, interests and level of ability across all three service streams.

Medicine management policies and procedures are implemented by staff and reflect safe medicine management practices.

The menu has been reviewed as meeting nutritional guidelines by a registered dietitian. Residents' special dietary requirements and cultural needs are met. Interviews with residents verified a high level of satisfaction with meals. Freezer temperatures need to be maintained within safe food handling guidelines.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness was displayed. Any maintenance issues are addressed and proactive maintenance carried out. Residents and family described the environment as meeting their needs.

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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Policies and procedures implemented meet the requirements of the standards. There were 19 residents who use restraint and one resident who uses an enabler at the time of audit. The service maintains a process to determine approval for all types of restraint and enablers. The areas requiring improvement from the last audit relating to reducing the use of restraint, and holding approval group meetings has been addressed.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and results reported through all levels of the organisation, including governance.

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	3	0	0	0
Criteria	0	39	0	3	0	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>	<p>FA</p>	<p>The facility manager is responsible for the management of complaints and there are appropriate systems in place to manage the complaints processes. The complaints register reviewed included 13 internal complaints for 2014 and 2015.</p> <p>The facility manager and chief clinical officer advised there had been a complaint to the District Health Board (DHB) since the last audit. Documentation reviewed indicates this complaint has been investigated by the provider and as a result improvements to service delivery have been implemented. The chief clinical officer interviewed advised this complaint had been closed out by the DHB. There have been no investigations by the Ministry of Health, Health and Disability Commissioner, Accident Compensation Corporation (ACC) or Coroner since the last audit.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place that ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and family interviewed demonstrated an understanding and awareness of these processes. Resident meetings are held monthly and residents are able to raise any issues during these meetings. This was confirmed during interview of residents and family and review of resident meeting minutes. Review of the collated resident and family survey for November 2014 evidenced families were satisfied with the response they received</p>

		<p>as a result of making a complaint.</p> <p>A visual inspection of the facility shows the complaint process readily accessible and displayed. Review of quality and staff meeting minutes and the facility manager's reports provides evidence of reporting of complaints to the governing body and staff. Care staff interviewed confirm information is reported to them via their quality and staff meetings.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Policy reviewed identified that interpreter services are available to residents of Ranburn Rest Home and Hospital (Ranburn) and offered to residents with English as a second language.</p> <p>Residents and family interviewed confirmed communication with staff is open and effective. Residents files reviewed evidenced residents were consulted and informed of any untoward event or change in care provision and included in care reviews. Residents and families responded very positively concerning effective communication from the resident and family survey collated in November 2014.</p> <p>The service has an open disclosure policy which guides staff around the principles and practice of open disclosure. Education on open disclosure is provided at orientation and as part of the education programme. Staff interviewed confirmed their understanding of open disclosure. Communication with family is documented in the residents' communication records. Incident forms evidenced families are informed when incidents occur.</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>	FA	<p>The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the service provided at Ranburn. A 'Business Plan 2015 – 2016' and a 'Quality and Risk Management Plan'– January 2015 to January 2016' for Ranburn were reviewed and include a vision statement, core values, quality objectives, quality indicators and quality projects, and scope of service. Also reviewed were documented values, mission statement and philosophy, which were displayed. The service philosophy is in an understandable form and was available to residents and their family / representative or other services involved in referring clients to the service.</p> <p>The Ultimate Care Group has established systems in place which defined the scope, direction and goals of the organisation at UCG facilities, as well as the monitoring and reporting processes against these systems.</p>

		<p>There is an 'Ultimate Care Group Clinical Advisory Group' (CAG) in place that includes two clinical services managers (CSMs), two regional managers, a facility manager, the chief clinical officer and clinical support advisor from UGC, who are responsible for reviewing clinical issues and policies and procedures following feedback from each of the UCG sites and from the governing body.</p> <p>Meeting schedules and minutes reviewed provide evidence that monthly quality/staff/infection control, registered nurse (RN), and residents' meetings are held. Meeting minutes are available for review by staff along with graphs of various clinical indicators. The facility manager (FM) provides weekly reports to the governing body. Reports include reporting on quality and risk management issues, occupancy, HR issues, quality improvements, internal audit outcomes, and clinical indicators.</p> <p>Ranburn has a facility manager (FM) who started in this position in August 2014 following a restructuring of positions. The business manager left employment in November 2014. The FM and chief clinical officer stated the FM had been in the position of clinical services manager at another UCG facility before this role and held a management position overseas as an associate director of nursing services. The FM is supported by a clinical services manager (CSM)/RN and a senior facility manager from another UCG facility. The CSM has been in the position since November 2014 and is responsible for oversight of clinical care provided to residents. The CSM held the position of RN at another UGC facility prior to this appointment. Support is also provided by a team leader/RN, the chief clinical officer, the clinical support advisor and the regional operations manager from UGC. The requirement from the last audit relating to a suitably qualified and/or experienced person appointed to the position of facility manager has been addressed.</p> <p>Ranburn is certified to provide medical and geriatric hospital level care, rest home level care and dementia level care. There are 71 beds provided and on day one of this audit there were 31 hospital residents, 21 rest home residents and 17 rest home dementia residents.</p> <p>Ranburn has contracts with the DHB to provide age related care (rest home, dementia, and hospital) and with the Ministry of Health to provide residential - non aged services for a resident aged less than 65 years.</p>
Standard 1.2.3: Quality And Risk Management Systems	FA	A quality and risk management plan for 2015 to 2016 was reviewed and is used to guide the quality programme and includes goals and objectives. There is an internal audit programme in place and completed internal audits for 2014 and January 2015

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>were reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register that identified health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk. A Health and Safety Manual includes relevant policies and procedures.</p> <p>Monthly quality/staff, infection control and RN meetings are held along with monthly residents' meetings. Meeting minutes were reviewed and these are available for review by staff. The facility manager's operations reports to UGC head office were reviewed and include reporting on occupancy, staffing and human resources management, environmental and property reports, financial reporting and general comments. Reporting to UGC head office is via an electronic database (GOSH Inscribe Database) which is used to input clinical indicators on a daily basis.</p> <p>Clinical indicators and quality improvement data is recorded on various registers and forms and these were reviewed on site. There was documented evidence that quality improvement data is collected, collated, and analysed to identify trends and corrective actions are developed, implemented and evaluated. Clinical indicators and quality and risk issues are reported to staff. Meeting minutes and reports reviewed also provided evidence of discussion of any trends identified, as well as reporting on infection control and health and safety. Staff interviewed reported they are kept well informed of quality and risk management issues that include clinical indicators. Copies of meeting minutes and graphs of clinical indicators are available in the nurses' stations for staff to view.</p> <p>Adverse events are documented on accident/incident forms and copies of these retained in the residents' files.</p> <p>Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed were relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly, including a policy for document update reviews and document control policy. The clinical advisory group (CAG) from UGC is responsible for reviewing policies and procedures. Staff signing sheets demonstrate staff are updated on new/reviewed policies, and this was confirmed during interviews of care staff. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies / revised policies.</p> <p>Current first aid certificates were sighted for all the RNs and the activity coordinators.</p>
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		Chemical safety data sheets are available that identify potential risks for each area of service. Planned maintenance and calibration programmes are in place and these were reviewed. All biomedical equipment had appropriate performance verified stickers and electrical safety stickers were current and in place.
<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, unplanned or untoward events on an incident/accident form which are then recorded on the UCG GOSH / Inscribe electronic database, and filed in residents' files. An 'Incident Management Form' is used to document all incidents that are escalated to UCG head office. Data reviewed for 2014 included summaries of various clinical indicators. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>Residents' files reviewed provide evidence of detailed communication with families following adverse events involving the resident, or any change in the resident's condition. This finding was confirmed during interviews of residents and family members, and review of the family survey for 2014 provided evidence that families are very satisfied with communication from staff at Ranburn.</p> <p>Staff confirmed during interview they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct, which was confirmed through review of staff files and other documentation. Policy and procedures comply with essential notification reporting including health and safety, human resources and infection control. The chief clinical officer advised there had been no essential notifications that required reporting since the last 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>	PA Low	<p>The skills and knowledge required for each position within the service is documented in job descriptions that outline accountability, responsibilities and authority. This was reviewed on staff files, along with employment agreements, reference checking, criminal vetting and completed orientations. Copies of current annual practising certificates were reviewed for all staff and contractors that required them. A performance appraisal schedule had recently been developed and a corrective action plan was sighted; however the majority of staff performance appraisals were not current.</p> <p>The FM and CSM are responsible for the education programme and the programmes for 2014 and 2015 were reviewed. The ACE 'Supporting the Older Person' education</p>

		<p>programme is provided. An enrolled nurse (EN) is the onsite ACE assessor and reports staff are encouraged to complete ACE education. Documentation reviewed evidenced all staff working in the dementia unit had completed the dementia modules and all other staff had either completed or commenced this training. Documentation evidenced all clinical staff have been provided with at least eight hours of training in the last year.</p> <p>Monthly staff education days were provided during 2014 and January 2015. Review of RNs' files and the competency register evidenced competency assessments for medication management are current. Competency assessments for restraint minimisation and safe practise were not current for all clinical staff.</p> <p>An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The CSM advised that staff are orientated for at least three shifts at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided.</p> <p>Care staff interviewed confirmed they had completed an orientation, including competency assessments (as appropriate). Care staff also confirmed their attendance at on-going in-service education.</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 clearly documented rationale for determining service provider levels and skill mixed so that a safe service is provided at Ranburn. The staffing rationale is based on 'SNZ:HB 8163:2005 Indicators for Safe aged-care and dementia-care for Consumers' - 'Table 4 Recommended hours per consumer'. The roster reviewed shows staffing levels exceed the recommended levels. 'The Ultimate Care Group Rostering Tool' is used by the facility manager to report to UCG head office. Registered nurse cover is provided 24 hours a day. The minimum number of staff is provided during the night shift and consisted of one registered nurse and four caregivers. The FM, CSM, and team leader/RN were rostered on call after hours and this is clearly displayed on the roster for staff.</p> <p>The FM stated they had recently reviewed the skill mix in the dementia unit and as a result, a RN was assigned specifically to the dementia unit from 8am to 5pm. At interview the FM and care staff stated that the RN in the dementia unit has made a difference, including a reduction in medication errors, better management of resident's care and care staff stated they no longer had to go out of the dementia unit</p>

		<p>to look for a RN when needed.</p> <p>Care staff interviewed reported that there is enough staff on duty and they are able to get through the work allocated to them. Residents and family interviewed reported there are enough staff on duty to provide care. The requirement from the last audit relating to the distribution of staff hours had been addressed.</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>With the exception to liquids and non-regular medicines, medicines are supplied by the pharmacy in a pre-packed administration system. None packaged medicines are individually supplied for each resident. The medicines and pre-packed medicine sheets are checked for accuracy by the RN when delivered. The pre-packed medicines and the signing sheets are compared against the medicine prescription. The GP conducts medicine reconciliation on admission to the service and when the resident has any changes made by other specialists. Safe medicine administration was observed at the time of audit in all three areas. One of eight bottles of eye drops was not dated when opened. This is not a systemic issue and the clinical nurse manager reports she will remind all appropriate staff to ensure this is done.</p> <p>The medicines, including controlled drugs and medicine trolley are securely stored in all areas. The temperature of the medicine fridge is monitored daily. The controlled drugs are signed out by two staff at each administration and a weekly stock count recorded in the controlled drug register. The pharmacy is involved in a six monthly medication reconciliation which was last undertaken in December 2014.</p> <p>All the medicine charts sighted had prescriptions that complied with legislation and aged care best practice guidelines. Each medicine is signed by the GP and had the required level of documentation to allow safe administration of the medicines. The prescriptions were legible, recorded the name, dose, route, strength and times for administration. The medicine charts record the regular, short course and 'as required' pro-re-nata (PRN) medicines for each resident. When medicines are discontinued, these are signed and dated by the GP. The medicine charts sighted had a current photo of the resident and recorded any medicine related allergies. Sample signature verification is recorded for all staff who administer medicines. All of the medicine charts sighted has been reviewed by the GP in the past three months.</p> <p>The standing orders comply with current legislation.</p> <p>Medication competencies were sighted for all staff that assist with medicine management; this included the RNs, one EN and a senior caregiver.</p>

		<p>The service's policies, procedures and self-administration guidelines are available should a resident wish to self-administer medicines. Currently there are no residents who self-administer. Staff interviewed verbalised their awareness of safe medication practices.</p> <p>Family/whanau interviewed and documentation in residents' files confirmed changes to medications are notified to family/whanau when this occurs.</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>	PA Low	<p>The service uses a menu which has been reviewed and approved by a registered dietitian as suitable for the older person living in long term care. (This is undertaken at organisational level).</p> <p>Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met. The cook confirmed during interview that residents with specific cultural needs have them identified and catered for. One example is a monthly 'boil-up' for a resident who identifies as Maori. This is confirmed by the resident when interviewed. The kitchen service receives a copy of the residents' nutritional profiles, with the residents' preference and special diets recorded which are updated as required. The residents and family/whanau interviewed report that the meals are very good and that they always have fluids available. Likes and dislikes are well managed.</p> <p>All aspects of food procurement, production, preparation, delivery and disposal complies with current legislation and guidelines. Faulty equipment is removed and replaced when required, such as the food mixer which was showing signs of wear and tear. Fridge and freezer recordings are undertaken daily and two of the three freezer temperature recordings do not meet requirements.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Residents' care plans describe the required interventions and supports required to assist the residents to achieve their documented goals. Care plans sighted contain information that is in line with assessment findings. Staff interviewed confirm that assessment tools are used to inform all care planning processes. Resident's personalised goals are documented where this can be determined. Examples include a resident wishing to remain independent and a resident having clearly set out interventions related to pain management.</p>

		Resident and family/whanau interviewed confirm care is delivered in a manner that is resident focused and that choices are given related to how and when care is delivered. This was an area identified for improvement in the previous audit and is now fully attained.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The file reviews undertaken contained documentation that guides staff actions and indicates which interventions are in place for each resident to ensure their needs are met. Residents and family/whanau interviewed confirm the services they receive meets their needs. The care plans reviewed are individualised and personalised to meet the assessed needs of the resident. Service delivery is resident focused.
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	Each resident has a social assessment undertaken upon entry to the facility. This information has been used when planning the activities calendar. There are planned activities for each service delivery stream, seven days a week. Sunday activities are undertaken by caregivers and the other six days the activities are undertaken by dedicated activities coordinators. The activities offered cover a broad range of items and are aimed to include meaningful activities for all residents. Attendance records sighted identify all residents participate in the activities offered to some degree. Planning identifies that the activities are modified according to the capability and cognitive abilities of the resident. The activities programme covers physical, social, recreational and emotional needs of the residents. This was an area identified for improvement in the previous audit and is now fully attained.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	The evaluations of care are conducted six monthly on the resident review/evaluation form. The care evaluations sighted are resident-focused, indicated the degree of achievement or response to the support and/or interventions, and progress towards meeting the desired outcomes. However, when changes are made to residents' care, this is identified on the care plan, but no evaluation is shown related to the changes made. Changes are clearly identified in progress notes, on the daily handover sheet and in the clinical diary. Short term care plans are in place for temporary changes. This is an area for improvement which the service is aware of and ongoing education is planned over the next two weeks for RNs as confirmed in documentation sighted. The

		<p>improvement required in the previous audit has been addressed.</p> <p>The residents and family/whanau interviewed report high satisfaction with the care provided at the service.</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 was displayed at the entrance to the facility that expires 1 August 2015. There has been no building alterations since the last audit.</p> <p>There is a maintenance schedule implemented. The lounge areas are designed so that space and seating arrangements provide for individual and group activities and are suitable for residents with mobility aids. The external areas are maintained, safe and appropriate to the resident groups and setting.</p> <p>Current calibration/performance verified stickers were observed to be on medical equipment. Electrical safety tags are on electrical items.</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>The service conducts monthly surveillance for infections across all services which are appropriate for the level of care offered, as documented in the infection control programme. Standardised definitions of infections are documented and used by staff when reporting infections. Staff interviewed understand the infection control reporting systems and surveillance data results are shared at staff meetings.</p> <p>Monthly data is reviewed and evaluated by the infection control coordinator (RN) and the report goes to head office where benchmarking occurs across all Ultimate Care Group facilities. The infection control data sighted identifies that the service has successfully lowered infection rates over the last two years. For example no urinary tract infections were recorded for December 2014 compared with two in December 2013.</p> <p>Staff and the infection control coordinator reported their knowledge and understanding of how an outbreak would be managed if it were to occur.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has an overarching risk and quality management systems in place that demonstrates compliance with the restraint minimisation and safe practice (RMSP) standard. The process of assessment and evaluation of enabler use is recorded. Review of the restraint register shows the number of residents using restraint has</p>

		<p>increased from 16 to 19 since the last audit and one resident was using an enabler. At interview the restraint coordinator and FM reported that the number of residents that were using restraint at the time of the last audit had decreased and new admissions had required restraint. Review of documentation evidenced the service actively strived to reduce the number of residents using restraint by assessment and the introduction of equipment including landing mats, sensor pads and low beds. A number of residents who used two types of restraint had been reduced to one type. The improvement required from the last audit relating to actively minimising restraint has been met.</p> <p>Approval group meetings minutes reviewed show meetings are held six monthly on a regular basis since the last audit, addressing a previous area requiring improvement.</p> <p>Staff interviewed and staff records evidenced guidance has been given on restraint minimisation, enabler usage and challenging behaviour.</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>Education programmes for 2014 and 2015 reviewed show training sessions provided monthly. The programme for 2015 has been extended and includes more topics. Staff interviewed stated they were provided with training as part of their orientation and attended on going education sessions. Registered nurses had current competencies for medicine management. Documentation evidenced attendance records, and individual training registers. A spread sheet reviewed shows the majority of performance appraisals are not current. Competency assessments for clinical staff relating to restraint are not current.</p>	<p>The majority of performance appraisals are not current for all staff. Competency assessments for restraint minimisation and safe practice are not current for clinical staff.</p>	<p>Provide evidence that all staff have current performance appraisals and all clinical staff have current restraint competency assessments.</p> <p>180 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 production, preparation, transportation, delivery and disposal comply with current legislation and guidelines. The kitchen has adequate equipment to cater for dietary services. Freezers are running too cold. The kitchen staff were aware of this but had not notified management. The temperatures are outside best practice food safety standards. Discussed with management at the time of audit.</p>	<p>Two of the three freezers being used in the kitchen had readings between negative 28°C and negative 29°C for over a month. This had not been alerted to management although the form completed stated this was required if the freezer readings went above or below negative 18°C to negative 20°C</p>	<p>Ensure all food storage meets the current guidelines.</p> <p>180 days</p>
<p>Criterion 1.3.8.2</p> <p>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.</p>	<p>PA Low</p>	<p>Evaluation of interventions in assisting residents progress is undertaken six monthly. This is confirmed in the files reviewed. If a change is made during the six month period for each file review the evaluation of the need for change is not shown. This was discussed with the clinical manager during the audit.</p>	<p>In three of the nine files reviewed, when changes to resident care had been made between the six monthly reviews no evaluation was documented related to the changes made.</p>	<p>Ensure evaluations are documented to show why a change was required.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.