The Ultimate Care Group Limited - Ultimate Care Rose Court

Introduction

This report records the results of a Certification 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:	Rose Court Lifecare
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 2015 End date: 22 July 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: 58

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

A certification audit against the Health and Disability Services Standards and the service agreement requirements of the local district health board (DHB) was undertaken at Ultimate Care Rose Court in Christchurch. The facility provides rest home and hospital services in 60 beds, and on the days of the certification audit the occupancy was 58. There were 25 hospital care residents and 33 rest home care residents. During the two days of audit, policies and procedures, staff files and residents' files were reviewed, observations made and residents, family members, staff, allied health professionals and the manager were interviewed.

Quality and risk management systems have been reviewed and are being implemented accordingly. The environment is appropriate for the use of the residents and well maintained. Positive feedback was provided by all persons interviewed, who consistently commented on the excellent care and support being provided and the commitment of staff and the management team. Staff were being supported to undertake a range of training opportunities with monthly education sessions provided. Competency of work is regularly assessed.

Two areas have been rated as continuous improvement (that is, beyond the standard normally expected) relating to two quality initiatives implemented to minimise falls and to reduce the rate of urinary tract infections in the facility. There is one area identified as requiring improvement relating to activity plans.

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.

The admission process for residents into the facility is planned and timely. Consent forms are provided prior to admission to ensure residents and family have time to consult with others and are fully informed.

Consideration of residents' rights during service delivery to allow for personal choices, acknowledging and supporting cultural, spiritual and individual rights and beliefs, and encouraging independence was evident. Residents and family interviewed reported that all staff were very respectful of their needs, that communication is consistent and appropriate, and they are given time for discussions to take place. They have a clear understanding of their rights and the facility's processes if these are not met.

Information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, is on display at the entrance to the facility, is available on admission in admission information packs and on request.

A clear complaints policy and procedure ensures all complaints are responded to in a timely and professional manner. Any complaints received have been minor and all have been resolved satisfactorily.

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.

Ultimate Care Rose Court is managed by an experienced and well qualified manager who has had significant experience in the aged care sector. She is well supported by the organisation's national team. Planning is detailed and is responsive to any changes required both at legislative and facility level.

A comprehensive quality and risk management system is in place with robust reporting that is electronically based and managed at a national level. Monthly reporting is generated back to the facility which provides comprehensive analysis and any trends are identified. There is a quality improvement plan which includes an annual calendar of internal audit activity to ensure all areas of the services provided are of a high standard. A suite of policies and procedures are current and reviewed regularly. The adverse events reporting system and subsequent corrective action planning, feed into the quality improvement cycle to manage any further risk and ensure continuous quality improvement occurs.

The staff report feeling well supported by the management. A sound recruitment and appointment system is in place and staffing levels meet all the requirements. A comprehensive training programme maintains a high level of competence of all staff.

Residents' information management systems meet requirements.

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.		Standards applicable to this service fully attained.

A detailed admission information package is provided that details processes for admission to Ultimate Care Rose Court. The information explains the need for all residents to be assessed prior to admission.

The facility has fully implemented the interRAI assessment programme. The clinical manager or registered nurse (RN) completes the assessment, from which an individualised, detailed care plan is developed. Regular reviews occur to reflect the resident's assessed needs. Short term care plans are developed when issues arise within the review timeframe and these were all noted to be closed out when resolved. Staff were observed providing care in a calm, respectful and dignified manner, reflecting the care plan content. This was also confirmed in family and resident interviews.

Resident falls are reviewed in detail and a quality initiative introduced to minimise falls to those who fall frequently. The outcome has resulted in a reduction in falls and improved wellbeing and quality of life for the residents demonstrating continuous improvement.

The general practitioner (GP) is interviewed during the audit confirmed the facility provides a high level of care and assessments and service delivery are appropriate and in line with her treatment recommendations.

An activities programme is managed and implemented by an activities person, providing a variety of group and individual activities to meet the interests of the residents. Residents' activities plans require some improvement.

A 'blister pack' medication system is implemented and care staff, assessed as competent to do so, follow the GP prescription record to administer the medications. The process was observed, demonstrating safe practice occurs. Policies and procedures, storage and reconciliation of medicines meet legislation and guidelines. There is oversight of medication management from an external pharmacist to ensure packs are updated as soon as changes occur.

A dietary profile is completed for each resident on admission and any special dietary needs are met. The kitchen service is managed from within the facility. A nutritional review of the menu occurred in 2015 and recommendations have been implemented. Personal likes and dislikes are catered for and special events are celebrated. Residents and family are complimentary of the food service provided. Appropriate monitoring of food transportation and preparation is occurring. All stored food is dated to ensure stock rotation occurs.

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.

The facility is purpose built and well maintained. The residents' rooms are kept clean, tidy, well ventilated and at a comfortable temperature. There are a number of communal areas which provide a variety of spaces for residents to use, including an activities lounge and a sun room. All rooms have their own ensuites. Easily accessed, safe and attractive outside areas are provided for use for residents. The building has a current building warrant of fitness.

Robust systems are implemented for the management of waste and hazardous substances by staff who have been trained in this area.

Emergency procedures are well documented for ease of use and available in a number of places around the facility. Regular fire drills are held and staff are well trained to respond in any emergency. A back-up generator is on site and relevant supplies for civil defence and other emergencies are located at the facility.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.	■	Standards applicable to this service fully attained.
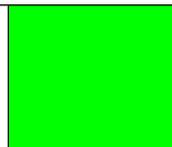
The management are committed to providing a restraint free environment and there is no restraint being used at the time of the audit. Staff have ongoing training in the management of any challenging behaviours. Policies and procedures meet all the requirements of the standard. Any use of enablers is for safety of residents in response to individual requests.

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.	■	All standards applicable to this service fully attained with some standards exceeded.
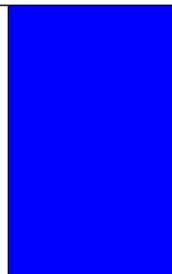
An infection prevention and control programme is described in the Ultimate Care Group organisation wide infection control manual. The manager for Ultimate Care Group has signed a commitment to supporting the programme and the infection control registered nurse oversees the staff education, updates of related policies and procedures and a surveillance programme. Staff undertake on-going training, receive updates on the incidence of infections and are given advice on any required actions to reduce infections at monthly meetings.

A quality improvement project has been implemented to reduce the number of urinary tract infections over a six month period. The project met expectations, continues, and has improved the quality of residents' lives demonstrating continuous improvement.

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	2	42	0	1	0	0	0
Criteria	2	90	0	1	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Interviews with residents and family, a review of records and observation during the audit verified that staff have knowledge and understanding of consumer rights and incorporate them into everyday practice. Records reviewed confirmed staff training occurs initially during induction and thereafter, annually.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Informed consent procedures are outlined in policy and are reflected in documentation reviewed. These included signed admission agreements and advance directives, written consent for influenza vaccination, transport, outings, photographs, names on door and care provision. Staff demonstrated knowledge of informed consent practices. Residents and family confirmed and provided examples that staff gain consent on a daily basis.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Policies and procedures include the right of residents to have an advocate or support person of their choice. Residents and family interviewed confirm that family and support persons are included in discussions relating to care provision. The residents' family communication record documents input from the family member in relation to all matters. Care staff interviewed were aware of the residents' rights to have a support person of their choice at any time.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and family interviewed verify that family and visitors of their choice are able to visit at any time. External community links are encouraged and enabled to continue, with examples provided. Progress notes, care plan content and family communication forms reviewed included references to regular outings and appointments.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaint / concern policy meets the requirements of Right 10 of the Code. Complaint forms are given to residents on arrival and are also available in the facility. The facility manager is responsible for investigating and managing complaints. All complaints are recorded in the complaint register. The complaint register confirms all required timeframes have been met. The issues raised are minor with no serious complaints being lodged. All files reviewed follow the process as per the organisational policy. A risk rating is applied to each complaint/concern and a risk matrix has been developed to guide staff. Any complaints of a serious nature are immediately notified to the chief clinical officer who then provides guidance to ensure the process is followed and support given as required. Every complaint is entered into the electronic quality system (GOSH) and becomes a part of the quality process. Corrective actions are initiated as appropriate. Staff interviewed confirm a sound understanding of the complaint process and the procedures to ensure all concerns are documented and addressed. All residents and families interviewed reported they had no concerns at

		this time and felt comfortable to raise any issues that may arise.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and family confirmed during interview that they are provided with information regarding the Code of Health and Disability Services Consumers' Rights (the Code), and the Nationwide Health and Disability Advocacy Service prior to admission to the facility. They verify that explanations regarding their rights occurred initially and on an on-going basis if they have a query. They are aware that an advocate may be appointed if needed. None of those interviewed have required the service. A large consumer rights poster, consumer rights' brochures and information on the Advocacy Service are available at the entrance to the facility, and include information on providing feedback, complaints and compliments.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	An initial care plan assessment and long term care plan documents reviewed include preserving independence, values, beliefs and cultural needs of residents, with further examples observed at the audit and provided during interviews with care staff. Residents and the family members interviewed have not been subject to, or witnessed, any signs of abuse or neglect. Those interviewed maintain all staff showed respect at all times by knocking when entering rooms, facilitating private conversations, understanding residents' particular values and beliefs and encouraging independence. These practices were observed during the audit and confirmed during staff interviews.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	Policies on cultural safety and Maori health provide guidelines for the provision of culturally safe services for Maori residents, including a section on cultural awareness. There is on-going training and involvement from the local marae. Ways of providing culturally safe care are in line with the Treaty of Waitangi expectations. One Maori resident interviewed and documentation verifies staff

		adherence to policies and procedures in relation to service provision and culturally safe practice.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Cultural needs of all persons within the facility is included within the Maori health policy and procedures. Residents and the family members interviewed verify the facility regularly ensures their individual values and beliefs are met. Examples are provided that confirmed that care staff ensure residents receive services that respect their individual values and beliefs. This was also observed during the audit.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Policy documents reviewed include guidelines to ensure residents are free from any discrimination, coercion, harassment, sexual, financial or other exploitation. Care staff interviewed demonstrated awareness of the residents' rights in relation to these areas. Residents and family interviewed verified there have been no issues relating to any coercion or exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Induction and orientation for staff are aligned to best practice processes. Each staff member has a written scope of practice included in their position description. Records reviewed and interview with staff verify that in-service education and on-going professional development is provided and supported by the organisation. Policies and procedures are current and reflect good practice guidelines. The facility has implemented the interRAI assessment programme to for all residents.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Ultimate Care Rose Court's 'Open Disclosure' policy and procedure includes a definition, describes key principles and explains expectations of open disclosure procedures for the service. Staff training, limits on disclosure, and references enhance the policy document. Residents and the family members interviewed confirmed that

		communication is appropriate and in a manner the resident can understand. Care staff are observed taking time to ensure when communicating with residents that they are understood and residents have adequate time to answer.
		The facility's nurse manager verified the facility has not needed to access interpreter services at all, although she could explain processes in place should these be required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The facility is part of the Ultimate Care Group. It has a CEO and seven national managers who provide relevant support to the facilities in the group. Ultimate Care Rose Court (Rose Court) has its own service plan which is written by the manager of the facility and approved by the regional manager. A comprehensive suite of planning documents is in place with a focus on quality aged care provision. The organisational vision and goals are on display at the main entrance and these form the basis for the Rose Court service plan, which details the planned goals and actions for the current year. This is reviewed annually. The manager completes weekly occupancy and monthly narrative reports to the regional manager. Monthly meetings are also held, which can be scheduled more frequently if required. The manager has been in the role for three months. She is a qualified RN who has experience in the aged care sector.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	In a short term absence of the facility manager, the clinical nurse manager is able to take over day to day management responsibility. For longer absences the organisation has its own relief manager who will take over the role as well as the regional managers who will be available if required.
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	FA	There is a detailed quality and risk management plan which is reviewed annually. The current plan is for the 2015-16 period. There is an organisational quality governance group comprising of the CEO and the

quality improvement principles.		senior management team, which oversees the overall quality programmes and consults with the regional managers and each facility manager. The group oversee the achievement of the objectives, goals and core values of the organisation to support sustained and continuous improvement. They meet six weekly and all managers receive updates and any changes to policies are sent. The specific facility plan details the responsibilities for the quality programme which is managed by the facility manager and the clinical nurse manager. The quality improvement programme in place incorporates feedback from residents/family/whanau and staff, invited regularly throughout the year.
		A range of quality indicators are monitored, including both clinical and non-clinical clinical indicators. The facility manager reports on these monthly using the electronic reporting system. A national Clinical Advisory Group takes responsibility for reviewing all clinical issues and policies and procedures for all sites. Monthly reports generated from all the data entered into the system give the manager both number and graphed details. These are analysed, trends noted and any corrective actions developed and implemented. Timeframes are agreed and automated reminders are sent to monitor these are on track and signed off when completed. The quality committee at the facility reviews all reports and minutes reflect the process is managed according to the policy and procedures.
		The quality improvement plan includes an annual calendar of internal audit activity and the month when each audit is completed. This covers all areas of the facility operation. The internal audits are up to date and provide a sound platform for improvement activity. Four continuous improvement projects have been undertaken this year; two clinical, a physiotherapy project and one involving staff education.
		The monthly staff meetings held are the opportunity to ensure staff are kept informed of quality activity in the facility and the wider organisation. The minutes of meetings sighted and staff interviewed confirmed staff are closely involved in quality improvement activity. All current projects and corrective actions are discussed and progress noted.
		Annual residents and relative surveys are included in the quality programme and staff meeting minutes are available at the facility for anyone to access.

		A risk management policy and plan details a systematic process which is used to identify, assess, manage and monitor risks both organisationally and at the facility level. The risk register documents all relevant details.
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	Within the quality management system folder there is a detailed national policy and relevant incident management and reporting. There is a process for escalating serious harm incidents to head office and the chief clinical officer. The Ultimate Care Group (UCG) template includes the clinical and non-clinical adverse events which are monitored. The incident reporting process begins with an incident documented on the paper form which is then entered into the 'GOSH' system to become a part of the monthly quality management cycle. The form includes documenting notification of family and medical professional as required. A copy of all non-clinical incidents is kept in a register and all forms involving residents are filed in the resident's notes. All incidents are reported to the manager who becomes involved as necessary. There is monthly analysis of incident / accident reports and the facility quality committee analyses collated data, identifies any trends and plans corrective action responses. Staff reported a clear understanding of the process for incident reporting. The register confirms families and residents are kept informed where appropriate. The facility manager reports the process for notification to authorities is clearly understood and actioned when indicated.
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	Policies and procedures for recruitment and appointment of staff reflect current legislation and good employment practice. All recruitment is currently managed by the manager, with support from the organisation's people manager. All checks are completed prior to any appointments. Professional qualifications are verified and filed. Other professionals who are independent of the facility also have relevant checks completed and the relevant qualifications are documented. All annual practising certificates (APCs) are current and securely filed. Staff files reviewed have the required documentation in place and performance appraisals

		are current. New staff receive a detailed orientation and an orientation pack is completed. They are then paired up with a more experienced staff member until there is confidence they are able to perform duties competently. All staff interviewed confirmed an orientation was completed and they felt able to carry out their duties as required. A comprehensive training programme is in place. An annual training schedule has been developed and there is also an annual education day for all staff that is mandatory to attend. This covers all facility wide requirements including advocacy, client rights, restraint and infection control modules. Each course of study is evaluated by staff and management. Records of all training attended are kept on staff personal files. Staff reported they have sufficient training and residents confirmed they feel staff are competent in their roles. Specific training for different roles within the facility is planned and implemented appropriately.
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 staffing rationale policy sets out the requirements for staffing. The rosters are compiled by the facility manager following the set formula to ensure adequate cover is in place at all times. The rosters are on a six week rotating basis. The current and the previous weeks rosters were reviewed and confirmed the requirements for staffing were met. The occupancy levels are generally consistent so the staffing requirements are also consistent. Staff report staffing levels were satisfactory to ensure they are able to provide effective support to the residents. Residents and families spoken to all confirmed the staff numbers are sufficient to ensure their needs are met.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	A review of records, interview with the clinical manager and documentation confirmed that information is entered into each resident's integrated file in a timely manner. Records reviewed were current and legible. Current residents' old notes and archived records are secured in a room

		specific for records. These were observed as organised and dated for easy retrieval.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Entry to service documents detail all requirements for both parties on admission to Rose Court. Records reviewed show a needs assessment and service co-ordination (NASC) assessment occurs prior to all admissions to ensure admission is appropriate. The facility's service agreement requirements have all been met in the files reviewed. Residents and family interviewed verify the facility ensured the admission was timely and carried out with dignity and respect, taking into account the family and residents' identified needs.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	One file of a discharged resident was reviewed. The clinical manager confirmed all discharges included the involvement of the resident, family and GP. A discharge form is completed and details any persons involved, any risks and measures to minimise the risk. The file reviewed was completed with evidence of family and GP involvement prior to the discharge.
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.	FA	Within the facility's clinical policies there is a suite of medication documents. Policies and procedures for medication management include each health professional's responsibility in relation to medicine prescribing, administration, reconciliation, dispensing, storage and disposal. The facility has a blister pack system in place for all residents requiring medication assistance. The blister packs are reconciled into the facility by the registered nurse every four weeks. Discontinued medications are returned to the pharmacy weekly, including controlled medications, as sighted in records signed by the RN and the pharmacist. The resident's prescription medication record is completed and updated by the resident's GP and administered by the facility's RN or care staff competent to perform the function. The records reviewed were legible

		and each record signed individually by the GPs. Prescription records consistently included the reason for pro re nata (as required) medications. When an alteration occurs the GP updates the record in the facility as sighted in records reviewed
		One registered nurse with a current medication competency was observed administering medications, demonstrating safe practice on the day of the audit. The medication trolley holds all current medication, blister packs and medication records and was observed to be locked and securely stored when not in use.
		Controlled drugs were reviewed and storage was in line with guidelines and legislative requirements. There is a separate fridge for medications and temperatures were recorded and within recommended guidelines.
		There was no residents assessed as being suitable to self-administer medications, however there are policies and procedures in place should this occur.
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	There are policies and procedures in place for all aspects of food service, delivery, preparation, service, storage and disposal and cleaning. A nutritional audit of the menus has been undertaken by a dietitian in 2014, and any changes to the menu content is recorded.
		The cook, who was interviewed, shares the role with another cook. She has been in the position for several years and is supported in her role by care staff. Kitchen duties are shared among the cooks and afternoon and night care staff.
		Dietary profiles are written on admission. These were sighted and included likes and dislikes, preferences for beverages, and any other special dietary instructions. The RN or clinical manager will inform the kitchen if there are any changes in dietary requirements. This was verified by residents interviewed who confirmed there is variety in the food provided and that food met their needs and preferences. Residents were consistently very complimentary of the cook.
		The facility kitchen is organised and well maintained. There is a separate dining room for residents, and the kitchen staff also cater for residents who prefer to eat in their own room. There is evidence that stock rotation

		occurs. Food waste is disposed of in the local rubbish and in the kitchen disposal unit. One resident with a weight issue is having this managed with supplements.
		Observation of the meal service confirmed that residents enjoy the meals provided. A review of residents' meetings minutes and survey results verified that residents were complimentary about the food and the main cook.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	Interview with the clinical manager and a review of records confirmed the facility declines prospective residents that are not suitable for a rest home or hospital environment. The clinical manager maintains a record of prospective residents and when a resident is not suitable they are referred to the NASC agency for appropriate placement. The clinical manager provided examples of such situations.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The clinical manager interviewed confirmed that prior to admission NASC completes an interRAI assessment to ensure the placement is appropriate, with the clinical manager and facility manager making the final decision based on the assessment. A RN completes appropriate assessments on admission to Rose Court, including a pressure area risk assessment, falls risk assessment, continence assessment, nutritional assessment, and if required, a wound assessment.
		An interRAI assessment is completed at least every six months, as verified in one recent record reviewed, and an updated care plan is completed based on the completed assessment, resident/family input and appropriate allied health input. Those reviewed were completed in a timely manner by the RN. If an issue arises within the evaluation period, an appropriate assessment tool is completed prior to the development of a short term care plan. Examples were reviewed and showed a consistent assessment and care planning processes.
Standard 1.3.5: Planning	PA Low	The facility's RN develops the initial care plan following an interRAI assessment within timeframes to safely meet the resident's needs.

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.		Residents' files reviewed verified the long term care plan was completed within three weeks of admission. The clinical manager explained that when progress alters the RN will develop a short term care plan, using appropriate assessment tools. Evidence was sighted to support this. Care staff demonstrated knowledge of care plan content.
		Each care plan reviewed was complete, comprehensive and included interventions that reflected the resident's outcome goals following the interRAI assessment. Residents and family confirmed their involvement in care planning and the review process. There is evidence of allied health interventions in care plans reviewed and this is confirmed during the GP interview.
		Activity plans are developed and reviewed by the activities personnel, however these do not include specific interventions and are not reviewed at the same time as the care plan.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	CI	The facility's RN documents appropriate interventions on the resident's short term or long term care plan, based on prior completed assessments and the interRAI assessment tool. Following analyses of resident's falls and the implementation of a quality project, two residents who were frequently falling have had a significant reduction in falls and an increased quality of life demonstrating continuous improvement.
		Progress notes are written by care staff and those sighted confirmed residents' needs were met and service delivery was provided in a timely manner. This was verified during interviews with residents, family and staff. The implementation review and evaluation of strategies of residents who fall frequently was evidenced in all documentation sighted.
		GP assessments sighted were detailed on the medical clinical forms in the integrated residents' files and the subsequent intervention included on the residents' short term care plans. The GP confirmed interventions were always implemented by the facility staff.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a	FA	A social activity profile was developed by the activities person following admission to the facility in files reviewed. An activity plan was developed

consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		following the completion of the resident's long term care plan. Alongside the activity plan is an attendance register. Progress notes were observed to be completed monthly and report on progress relevant to the resident's individual activity. Interventions and evaluations require some improvement as indicated in criterion 1.3.5.2.

The general activity programme includes local shopping run, church services, arts and crafts, outings, singing group visits, reading, quizzes, puzzles, bowls, bingo, entertainers; sing a longs, exercises, stories, word games, newspaper reading, visits to the local café. Residents and family interviewed were very happy with the content and variety of activities provided. |
| Standard 1.3.8: Evaluation

Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plan reviews are the responsibility of the RN. During interview the clinical manager reported that when progress is less than expected a short term care plan has been developed, and evidence in files confirmed this occurs, including closing these out when the issue is resolved, or transferring the issue to a long term care plan. Examples were sighted where this has occurred. The detail of evaluations is a strength of the documentation reviewed. Progress toward meeting outcomes is detailed. Files reviewed verified care plan evaluations were completed at least six monthly as required, and often within three months. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | A review of integrated files, resident and family and GP interviews provided evidence of referral to other health and disability services. During interview with the clinical manager examples were discussed and documentation reviewed of referrals to allied health services. The clinical manager also confirmed that, if required, the facility will accompany residents on appointments if the family member is unavailable. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances

Consumers, visitors, and service providers are protected from | FA | There are chemicals / hazardous substances policies and protocols which outline the processes the organisation uses to manage waste. The Health and Safety Committee has a role to minimise risk and ensure |

harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		these processes are followed. The storage of chemicals is detailed. An outside firm is contracted to supply all chemicals and cleaning products with relevant labelling, training and data sheets supplied. All are stored securely. Cleaning products are all colour coded for ease of identification. An outside storage area for all gardening and maintenance materials is kept locked and accessed only by authorised staff. Staff have regular training in the management of waste and hazardous substances and training records confirmed this. Aprons, gloves and masks were available in all areas where personal cares are involved and also in the laundry. Staff were observed using these throughout the facility as appropriate during the audit. Any incidents are reported and documented and then fed into the quality management system which includes monitoring of all the procedures as a part of the internal audit programme. Staff reported they were clear about the process for incident reporting in this area.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building warrant of fitness (BWOF) sighted is current and expires on 1 April 2016. Regular testing of electrical equipment is completed and calibrated as necessary. The facility is purpose built with wide hallways around the whole facility with handrails installed to assist with safe mobility for the residents. All outside areas are easily accessed from the facility .These include an enclosed courtyard and garden area which is well maintained and a number of other smaller outside areas that are easily accessed and provide convenient spots to move about outside. A facility van is well used and staff are appropriately trained and qualified to provide transport for residents.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to	FA	All rooms have their own ensuites. There are an additional two fully accessible toilets provided for use by the residents. All bathrooms are hygienic and well maintained with privacy locks on all doors. Visitor and

personal hygiene requirements or receiving assistance with personal hygiene requirements.		staff toilets are available around the facility.
		The hot water temperatures are checked regularly with internal audits completed. Hand sanitizers are provided in all areas of the facility including all communal areas, entrances, residents' rooms and bathrooms, hallways and staff areas.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	The residents' rooms are all single rooms which are cleaned to a high standard and tidily presented. All rooms have the resident's name clearly displayed on the door. Many residents have their own television. There is ample space for manoeuvring of mobility aids. Rooms are able to accommodate hoists if required and all areas were observed to be free of barriers to impede movement of residents who use aids. All residents spoken with expressed satisfaction with their rooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The hospital and the rest home wings both have their own dining rooms and lounge areas. There is also a large lounge that is shared with village residents. A large activity room, a television room, a sun room and a number of other smaller sitting areas mean there are ample communal areas for residents to use when they are engaging in activities or entertaining family. All the rooms are warm and light with plenty of suitable seating and were observed to be well used by the residents. The furnishings are appropriate and well maintained.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The laundry process was observed to reflect safe and hygienic management of all dirty, soiled and clean laundry. Internal audits are done on a regular cycle to monitor effectiveness with results being used to ensure standards are maintained. Colour coded bags are used to transport and deliver the laundry and a clear process is in place to provide appropriate separation of the clean and dirty laundry. The laundry manager was able to describe the process used for both the laundry process and management of the detergent supplies in a way that demonstrated a clear understanding. Data sheets were displayed. The training records showed the laundry manager and the cleaners have

		recently attended relevant training sessions.
		The cleaners' trolleys have a locked safe for storage of cleaning products while they are working. These are securely stored when not in use. The cleaners interviewed were able to detail process and procedures required for the safe use of any chemicals and cleaning products.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are polices / procedures and guidelines for emergency planning, preparation and response. Disaster planning guides direct the facility in their preparation for disasters and describe the procedures to be followed for fire evacuations and regular practices. Emergency evacuation procedures are located in reception and the nurses' stations. This includes procedures for fire, earthquake, bomb threat, storm and flooding. The fire evacuation drill is held six monthly with the last one being completed on 23 March 2015. Civil defence and emergency food and supplies are on site for use in a civil defence emergencies. A 'telephone tree' has been developed to ensure all essential staff are alerted if there are emergencies and lists of all relatives, should notifications be required. Staff training for emergencies occurs regularly and orientation includes an emergency training module. The approved evacuation plan is sighted. This was completed in 2007. In the event of a power failure there is a backup generator which will operate for an hour, and then the facility has an agreement for priority for delivery of a mobile generator if needed. All rooms are equipped with a call bell which goes directly to staff pagers. The bells are also located in all the bathroom and toilet areas. The manager reports no concerns have been raised recently around response times. All bells were observed to be answered promptly during the audit. The doors are locked at night and windows checked. A night bell is used for any access required after hours. Residents interviewed all felt safe in the facility.

Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	The facility is spacious, light and well ventilated with opening windows in all areas. As the audit was conducted during winter, the central heating was on and the environment was warm and comfortable. Temperatures are checked on a regular basis. All rooms have opening windows with adequate natural light.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Infection control policy and procedure documentation describes the infection control programme. During interviews, staff informed they are aware of the documents and that they receive on-going training on infection prevention. An organisational structure illustrates the lines of accountability for the management of infection prevention and control, including where advice may be accessed. Roles and responsibilities of the infection control RN are described and include the reporting process through the clinical manager, quality system and head office. The facility manager has signed off their support for the infection control programme for 2015 following a review of it in 2014. Expectations of unwell staff and of visitors are outlined in the policy documents and a sign requesting unwell people not to enter the facility is at the front entrance.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	Infection prevention and control is primarily managed by an IC RN who undertakes infection control education annually. The infection control RN informed she can access the district health board infection control nurse, the local GP, or laboratories in Christchurch should additional advice be required. These processes are described in policy documentation and were confirmed by the clinical manager.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and	FA	Written policies and procedures on infection prevention and control were reviewed in 2015. The clinical manager described how these are applicable for this service. Policies reviewed comply with relevant

control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		legislation and current accepted good practice.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff education sessions on infection prevention and control are delivered by the IC RN. Staff confirmed they are provided with information about the incidence of infection control at each monthly staff meeting and that they are provided with education at these meetings relevant to an IC topic. Training records and staff meeting minutes confirmed these training sessions are occurring and showed the topics of hand-washing and the introduction of additional fluids for residents are two topics provided in 2015. Infection control topics are also covered in some modules of the national certificates that all care staff undertake. Good hand hygiene processes are posted above all hand basins in the facility.
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.	CI	Infection control policy and procedures, which include the definitions of infections, describe the processes for the surveillance of infections. The infection control RN and the clinical manager are responsible for infection surveillance and for reporting the data, analyses and recommended actions to the facility manager on a monthly basis. Infection surveillance information is provided at monthly staff meetings and included electronically to head office. Short term care plans are used for the management of residents with an infection. Information about each infection is transferred into an infection control surveillance form and into a separate review form, where identified trends and corrective actions are documented. Examples were sighted and the information showed that infection rates overall were not high. Regardless of this a quality improvement project was implemented to reduce the rate of urinary tract infections. The results have shown a significantly reduced incidence of that type of infection, with improved outcomes for the residents demonstrating continuous improvement.

| Standard 2.1.1: Restraint minimisation

Services demonstrate that the use of restraint is actively minimised. | FA | The organisation has a suite of policies, procedures and forms in relation to the use of restraints and enablers. There is a definition of restraint which is consistent with these standards, as is the definition of an enabler. There is a flow chart to guide the decision making before any restraint is considered and a consent process for residents / family / whanau or enduring power of attorney (EPOA). The policy for restraint states any use of restraint is only as a last resort and a number of alternative strategies are implanted if required. There are relevant forms for consent, application, approval group recommendations, monitoring and review. The restraint coordinator confirmed no restraint was currently in use and the aim is to continue having a restraint free environment for all residents. A register is used to document the three enablers (bed rails) in use. One resident asks for a lap belt to use when travelling outside the facility.

Staff reported they are clear about the use of restraint and that enablers are voluntary and at the request of a resident. Regular training occurs and this is documented in the training plan. Although these enablers do not restrict normal movement, they are documented on a register and in the residents' care plans which are reviewed regularly.

All residents are monitored overnight by staff on duty. |

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.

Citerion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (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 Low	Initial care plans, long term and short term care plans and activity plans are developed within designated timeframes. The facility RN reviews care plans and alters interventions as appropriate. The activity plans include a generic goal for example: "To maintain high self-esteem and continue good physical health" for most of the residents. Interventions are also non-specific and generic for example: "To engage socially with others as appropriate". The intervention does not detail how this will occur for each individual resident. Activity plans are reviewed by the activity person three monthly, but not at the same time as the care plan.	Activity plans include a generic goal and non-specific interventions that are also generic to most residents. Activity plans are not reviewed at the same time as the care plan as required in the service agreement (D16.5 c iii).	Activity plans include goals and intervention specific to the needs and outcomes of each resident. Activity plans are reviewed at the same time as the care plan review. 180 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.

Citerion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
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.	CI	Documentation reviewed showed there has been extensive work and improvement on assessment, care planning and the evaluation process for those who frequently fall. An analyses of residents' falls, and those in particular who frequently fall, demonstrated an improved, detailed and individualised positive resident outcome. Two care plan files were reviewed in depth particularly in relation to falls. Each file reviewed included individual goals identified, as confirmed in resident and family interviews. Realistic and detailed interventions were written that would enable the resident to meet their goal of reducing the number of falls. Following this, evaluations were clear and described the progress toward meeting the outcome, and the feedback provided	Due to extensive and continuous improvement of strategies for those residents who were frequently falling, documentation confirmed this is beyond the expected full attainment. A review of the process and residents' improved quality of life has been measured as part of minimising falls and has shown positive outcomes for residents.

		to the resident. Residents, family and staff identified additional approaches to enable them to safely mobilise. These strategies were implemented and a further analyses undertaken and documented.	
		Residents and family were further surveyed to gain feedback on the value of their input and the reduction in falls and improved quality of life for the resident. This team approach to minimising falls for individual resident who fall frequently demonstrates continuous improvement. An interview and observation of both residents confirmed their increased quality of life since the implementation of individualised strategies, including on-going evaluation.	
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	CI	The clinical manager collates monthly report sheets and the information is transferred to an organisation wide electronic data analyses sheet listing specific infections such as urinary tract, skin and wound, eye, respiratory tract and gastro-enteritis infections. On analysing the data, the facility introduced a quality improvement project to reduce the number of urinary tract infections by 50% over a six month period as part of an organisation wide key performance indicator process. Five key changes were identified for improvement: 1: To implement regular fluid rounds in between afternoon tea and dinner. This has continued in the winter months and is enjoyed by the residents, with a choice of warmer drinks. 2: Knowledge – residents understanding that	The facility has demonstrated a quality improvement project to reduce the number of urinary tract infections by 50% within a six month timeframe, and having achieved this positive outcome are continuing with the initiative, including further evaluations demonstrating continuous improvement.

		regular fluid intake can minimise the risk of a urinary tract infection (UTI).	
		3: Increased staff education – including at the monthly meetings with the RN's.	
		3: Medical diagnosis – those with dementia often forgot to drink; staff education on how to manage this for these residents was included.	
		4: Increased staff awareness of early symptoms of urinary tract infections.	
		The clinical manager and the quality team evaluated outcomes in February 2015	
		Evaluations have been encouraging with benefits to residents showing a 50% reduction in UTI's in the initial implementation of the quality improvement project. Residents interviewed confirmed the reason for and benefits of the extra fluid round. Following the evaluation the quality team with input from staff and feedback from residents and family have continued with the initiative.	

End of the report.