

The Ultimate Care Group Limited - Oakland Lifecare

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:

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| Legal entity: | The Ultimate Care Group Limited | |
| Premises audited: | Ultimate Care Oakland | |
| Services audited: | Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical | |
| Dates of audit: | Start date: 27 October 2016 | End date: 28 October 2016 |
| 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: | 62 | |



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

General overview of the audit

Ultimate Care Oakland provides residential care for up to 84 residents who require hospital, rest home and physical and or intellectual disability level of care. On the day of audit there were 62 beds occupied. The facility is operated by the Ultimate Care Group Limited.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff, a general practitioner and other allied health professionals.

Areas requiring improvement from this audit relate to the internal audit programme not being followed; analysis of quality data; corrective action plans and review to show effectiveness; currency of restraint education and competencies; interRAI assessments; incomplete resident documentation concerning care delivery; care plans not updated and the lack of short term care plans developed when the health status of a resident changes.

Consumer rights

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| 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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Information regarding residents' rights, access to interpreter services and how to lodge a complaint was available to residents and their families. The complaints register is current and all complaints have been entered. Residents and their families reported their satisfaction with open communication with staff.

There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

Organisational management

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| 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. A business plan and quality and risk management systems are fully implemented at Ultimate Care Oakland and include a documented scope, direction, goals, values, and a mission statement. Systems are in place for monitoring the service, including regular reporting by the facility manager to head office.

The facility is managed by a facility manager who has a background in management. The facility manager is supported by a clinical services manager. The clinical services manager is responsible for oversight of the clinical service in the facility.

Quality and risk management systems are in place. There is an internal audit programme and an up to date hazard register. Adverse events are documented on accident/incident forms. Accident/incident forms and quality meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Quality, staff and resident meetings are held on a regular basis.

The risk register evidenced review and updating of risks and the addition of new risks. The health and safety representative has attended training in the Health and Safety at Work Act (2015) requirements.

Human resources processes are followed. There are policies and procedures on human resources management. Staff have the required qualifications. An in-service education programme is provided and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on best practise. Registered nurses are rostered on duty at all times. The clinical services manager and senior registered nurses are on call after hours.

Continuum of service delivery

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| <p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p> | | <p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
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Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are supported by care and allied health staff, including a physiotherapist and two designated general practitioners. On call arrangements for support from senior staff are in place. Shift handovers, communication sheets and frequent updates of residents' progress notes guide continuity of care.

Individualised care plans are developed within required timeframes, and include a range of clinical information. Resident's long-term nursing care plans are reviewed regularly to evaluate progress towards identified goals.

Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by two qualified diversional therapists provides residents with a variety of individual and group activities and helps maintains their links with the community. A facility van is available for outings.

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

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Most residents expressed satisfaction with meals.

Safe and appropriate environment

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| 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 is displayed. There have been no structural alterations to the building since the previous audit.

Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. On the days of audit there were 10 residents using restraint and one resident using an enabler.

Infection prevention and control

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| 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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Appropriate aged care specific infection surveillance is undertaken. Data is analysed and results reported through all levels of the service. Follow-up action is taken as and when required. Surveillance results are also benchmarked with other UCG facilities.

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 | 10 | 0 | 3 | 3 | 0 | 0 |
| Criteria | 0 | 31 | 0 | 5 | 3 | 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 |
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| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents on admission and there is complaints information and forms available within the facility.</p> <p>The complaints register showed 16 complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes specified in the Code. Action plans reviewed show any required follow up and improvements have been made where possible.</p> <p>The facility manager is responsible for complaints management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>The facility manager (FM) reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, DHB, Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p> | FA | <p>Resident records included evidence of open disclosure and timely communication with residents/families. Communication was documented in family communication sheets, on accident/incident forms as well as documented in the residents' progress notes. Family members stated they were informed in a timely manner about any changes to the resident's status and appreciated the ongoing communication with staff. Evidence was sighted of both families, and where possible, residents, having input into the care planning process. Staff were observed</p> |

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| <p>effectively with consumers and provide an environment conducive to effective communication.</p> | | <p>communicating effectively with residents and family. Interpreter services can be accessed from the local District Health Board when required.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the service provided at Ultimate Care Oakland (Oakland). A 'Quality and Risk Management Plan' was reviewed and included a vision statement, core values, quality objectives, quality indicators and quality projects, and scope of service. Also reviewed were documented values, mission statement and a philosophy of resident centred care. The service philosophy was 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 Panel' (CAP) in place that is responsible for reviewing clinical issues and policies and procedures following feedback from the UCG facilities and from the governing body.</p> <p>Meeting schedules and minutes reviewed evidenced that monthly quality, staff, registered nurse (RN), caregivers and residents' meetings are held. Meeting minutes were available for review by staff along with graphs of various clinical indicators. The FM provides weekly and monthly reports to the governing body. Reports included reporting on quality and risk management issues, occupancy, HR issues, quality improvements, internal audit outcomes, and clinical indicators.</p> <p>The facility manager (FM) has been in the role of FM since February 2015, prior to that they were the acting facility manager. The facility manager has a background in management and has attended leadership management courses since the previous audit. The FM is supported by an experienced clinical services manager (CSM) / registered nurse (RN) and a team leader/RN. The CSM has been in this role since December 2015 and is responsible for oversight of clinical care provided to residents. The CSM has experience in the aged care sector and prior to this appointment held the position of care manager/RN in other facilities. The senior management team from UCG head office also provide support as required.</p> <p>Oakland is certified to provide medical and geriatric hospital level care, rest home level care and physical and / or intellectual disabilities residential care. There are 84 beds provided. The FM advised that apart from seven rest home beds, all other beds have been approved for either rest home or hospital use. On day one of this audit there were 39 hospital residents, 16 rest home residents and seven residents aged less than 65 years with a physical and / or intellectual disability.</p> <p>Contracts with the DHB include aged related residential care and long term support – chronic health conditions</p> |

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| | | (residential). The service also has a contract with the Ministry of Health to provide residential – non-aged care. |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | PA Low | <p>A quality and risk management plan guides the quality programme and included goals and objectives. An internal audit programme is in place and completed internal audits were reviewed. The programme has not always been followed and there are audits completed after the scheduled month and others not completed. Risks are identified, and there was 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 was available that included relevant policies and procedures.</p> <p>Monthly quality and various staff meetings are held along with residents' meetings. Younger residents with a physical disability have their own meetings. Minutes evidenced good communication between the service and the younger residents. Meeting minutes were reviewed and these were available for review by staff. The facility manager reports to UCG head office include reporting on occupancy, staffing and human resources management, environmental and property reports, financial reporting and general comments. Reporting to UCG head office is via an electronic database which is used to input clinical indicators daily.</p> <p>Clinical indicators and quality improvement data was recorded on various registers and forms. Data consists mainly of numbers and graphs. There is some analysis of data, however, this is inconsistent and basic and any trends identified were not documented. The CSM reported they discuss any trends at the various meetings, however, this was not documented in the any of the meeting minutes reviewed. Meeting minutes evidenced reporting of numbers of clinical indicators and graphs including bench marking with other UCG facilities and another provider of aged care facilities. Corrective actions are developed and implemented to improve service delivery following completion of internal audits. Evidence of closing out corrective actions and review to evidence effectiveness was inconsistent. There was no evidence of corrective actions following the 2016 relative/family satisfaction survey. Adverse events are documented on accident/incident forms and copies of these were retained in the residents' files.</p> <p>Relevant standards were identified and included in the policies and procedures manuals. Policies and procedures were reviewed that were relevant to the scope and complexity of the service, reflected current accepted good practice, use of the interRAI assessment tool, and reference legislative requirements. Policies / procedures were 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 CAP from UCG is responsible for reviewing policies and procedures. Staff signing sheets demonstrated staff had been updated on new/reviewed policies, and this was confirmed during interviews of care staff. Care staff interviewed confirmed the policies and procedures provided appropriate guidance for the service delivery and they were advised of new policies / revised policies.</p> <p>Younger residents with a physical disability expressed satisfaction with regards to making decisions. Younger residents live throughout the facility rather than being all together in one area and they reported this was their</p> |

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| | | choice. Younger residents have electronic equipment and all necessary aids to help mobility and independence. |
| <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 are documenting adverse, unplanned or untoward events on an accident/incident form. These are collated by the clinical services manager. The original is kept in the residents' files. Data includes numbers and graphs of various clinical indicators. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The FM advised there have been two essential notification (Section 31) to the Ministry of Health since the previous audit. One relating to a resident admission and the other concerning a power outage. Documentation confirmed this.</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>Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, completed orientation, competency assessments and police vetting.</p> <p>The education programme for 2016 was reviewed. There was evidence indicating in-service education is provided for staff utilising various methods of delivery including in-house sessions and study days and external education. The FM advised the study days will be replaced with on-line learning. Individual records of education are maintained electronically as are competency assessments. Files for recently employed staff evidenced competency assessments for restraint as part of their orientation. The spreadsheet for education evidenced six clinical staff have received restraint education and restraint competences for all clinical staff are not current.</p> <p>The FM advised a New Zealand Qualification Authority education programme will be re-introduced in the new year for 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 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 and annually thereafter. Orientation for staff covers the essential components of the service provided.</p> <p>Staff performance appraisals are current. Annual practising certificates are current for all staff and contractors who require them to practice. There are two nursing staff who have interRAI training and current competency to</p> |

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| | | <p>undertake these assessments. Two other interRAI trained nursing staff have resigned in the past six months. (Areas for improvement is identified in relation to interRAI assessments against criteria 1.3.3.3 and 1.3.8.3.)</p> <p>Care staff confirmed they have completed an orientation, including competency assessments. Care staff also confirmed their attendance at on-going in-service education and currency of their performance appraisals.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | FA | <p>There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift. The clinical services manager and senior RNs are on-call after hours. Care staff interviewed reported there was adequate staff available and that they can get through the work allocated to them. Residents and families interviewed reported the number of staff on duty is adequate to provide them or their relative with safe care. Observations during this audit confirmed adequate staff cover was provided.</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> | PA Moderate | <p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using a hard-copy system was observed during the audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. Not all medications sighted were within current use-by dates.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration, and both staff observe the medication being administered. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridges reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The service has recently identified that the required three monthly GP medications review are not consistently recorded on the medicine chart, and is working to address this. Of the 19 medication charts reviewed, only one did not include evidence of</p> |

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| | | <p>medication review.</p> <p>There are three residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the CSM and entered into the GOSH system. The resident and/or the designated representative are advised. Refer also to criterion 1.2.3.8.</p> <p>Standing orders are not used by the service.</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> | FA | <p>The food service is provided on site by an experienced cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, such as lip plates, is available to meet resident's nutritional needs.</p> <p>There are a number of small dining areas around the facility, which residents reported as creating a homely atmosphere during meals. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. All residents spoken with enjoyed the main meal, which was served at lunchtime, but several felt that the evening meals were not as enjoyable.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and</p> | PA Moderate | <p>Documentation, observations and interviews verified the provision of care provided to residents was not always consistent with their needs, goals and the plan of care. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p> |

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| desired outcomes. | | |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>The activities programme is provided by two qualified and experienced diversional therapists, supported by an assistant and a number of volunteers.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated at least six monthly.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Group activities and regular events are offered, and included exercises, crafts, entertainers, weekly outings, church services, sunshine club, music therapy, bingo and happy hour. Several residents said how they had enjoyed the Octoberfest event held earlier in the week and were now looking forward to the forthcoming Melbourne Cup celebrations.</p> <p>There was more limited evidence of one-on-one activities being provided. The activities programme is discussed at the minuted residents' and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents confirmed they find the programme interesting and enjoyable. A review of the activities plans for two residents aged under 65 years confirmed that efforts had been made to ensure their activities programme promoted their ongoing involvement in the community, and reflected their individual needs/interests.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | PA Moderate | <p>Resident care is evaluated every shift and reported in the progress notes each shift for hospital-level residents, and at least daily for rest home residents. Formal care plan evaluations are completed every six months by the RN, and in the clinical files reviewed these evaluations were detailed. Where progress is different from expected, the service does not consistently respond by initiating changes to the plan of care, or developing short term care plans for more acute, time-limited events. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p> | FA | <p>A current building warrant of fitness is displaying in the facility. There have been no alterations to the building since the previous audit.</p> |

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| environment and facilities that are fit for their purpose. | | |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastrointestinal, and respiratory tract. When an infection is identified, a record of this is documented, and then entered into the organisation's GOSH system. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The infection control coordinator reviews all reported infections which are reported to the CSM and FM. This information is reported to UCG via the facility manager, and benchmarked within the group. Surveillance results are reported to the CQI meetings and shared with staff via regular staff meetings and at staff handovers.</p> <p>Surveillance results are then shared with staff at the registered nurses and general staff meetings, as confirmed in meeting minutes sighted and interviews with staff.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>The facility demonstrated they are actively reducing the use of restraint. There were 10 residents using restraint and one resident using an enabler during the audit. The restraint register is current and updated. The policies and procedures have good definitions of restraints and enablers. The process of assessment and evaluation of enabler use was recorded. The restraint coordinator and care staff demonstrated knowledge about restraints and enablers and how they are actively trying to reduce the use of restraint.</p> |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p> | PA Low | <p>A quality and risk management plan-Oakland - January to December 2016 guides the quality programme and includes planning and responsibility, a mission statement, care values and objectives and goals. Quality improvement data is reported to UCG head office via an electronic system on a regular basis. Quality data can be accessed electronically and includes clinical indicators using graphs and benchmarking with other UCG facilities and another company with similar facilities. Staff interviewed including the facility manager, clinical services manager, health and safety representative and care staff demonstrated an understanding of the quality and risk management systems. The internal audit programme for 2016 evidenced the programme is not always followed. Some audits are late or have not been completed.</p> | <p>The audit programme has not always been followed. The medication audit for August, the clinical files audit for September and the audits for October including restraint and cleaning have not been completed. Other audits have been completed after the scheduled month.</p> | <p>Provide documented evidence that the internal audit programme for 2016 is followed.</p> <p>90 days</p> |
| <p>Criterion 1.2.3.6</p> <p>Quality</p> | PA Low | <p>Quality improvement data is being collected and collated on a regular basis, including clinical indicators, and graphs are</p> | <p>Apart from graphs, analysis of quality data to identify any</p> | <p>Provide documented evidence that quality</p> |

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| <p>improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p> | | <p>generated. There is some evidence of analysis of data, however this is inconsistent. There was no evidence of any trends identified apart from graphs. The CSM advised there is discussion at the meetings around analysis and identifying any trends and staff confirmed this. Meeting minutes evidenced reporting of collated numbers of clinical indicators only. There was no evidence of discussion related to analysis and trending of quality data.</p> | <p>trends is not consistently documented. The only analysis documented were statements such as “numbers increased” and “remains high and care required”. Meeting minutes include numbers and benchmarking of clinical indicators, including but not limited to falls, bruising, skin tears medication errors, behaviours, pressure areas and infections.</p> | <p>data is comprehensively analysed to identify trends and the results reported back to staff.</p> <p>90 days</p> |
| <p>Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p> | <p>PA Low</p> | <p>Corrective action plans are being developed and implemented for deficiencies identified following internal audits. The relative and residents’ satisfaction survey for 2016 identified deficits, however, there was no evidence of any corrective action plans. Meeting minutes, apart from the quality minutes, do not consistently document who is responsible for the corrective action, time frames for completion and sign off.</p> | <p>A corrective action plan has not been completed following the relative and resident satisfaction survey completed this year. Meeting minutes, apart from the quality meetings, do not consistently document the staff member responsible for the corrective action, the timeframe and any sign off that the action has been completed.</p> | <p>Provide documented evidence that: (i) corrective action plans are developed, implemented and reviewed following all deficits identified; (ii) meeting minutes state who is responsible for the corrective action, the timeframes for completion and sign off once the corrective action has been completed.</p> <p>90 days</p> |
| <p>Criterion 1.2.7.5 A system to</p> | <p>PA Low</p> | <p>An education programme covers all required subjects. Inservice sessions and study days have been provided as well as education offered externally. The FM advised on-line</p> | <p>Apart from six clinical staff, restraint education has not been provided during 2016.</p> | <p>Provide documented evidence that: (i) all clinical staff have</p> |

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| <p>identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p> | | <p>learning is to be introduced next year and a New Zealand Qualification Authority education programme is to be re-introduced. Medication competency assessments are current for all staff who are responsible for medicine management. An electronic data base records all education and competencies for staff. Six clinical staff have received restraint education and apart from new staff, restraint competency is not current. Staff interviewed were uncertain as to when they last completed a competency assessment.</p> | <p>Competency assessments are not current for all clinical staff apart from new staff who have completed this as part of their orientation.</p> | <p>attended restraint education and that this is on-going; (ii) all clinical staff have current competency assessments.</p> <p>90 days</p> |
| <p>Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p> | <p>PA Moderate</p> | <p>With two exceptions, all aspects of medication management comply with legislation, protocols and guidelines. Medications in two of the service's medication trolleys and medication rooms were reviewed, with four expired pro re nata medications identified in one of the medication trolleys. Two containers of eyedrops in current use did not have the date of first use recorded, and one container of eyedrops had been opened more than 30 days earlier but not replaced.</p> | <p>Medications are not replaced when past their expiry date.</p> <p>The first date of use of eyedrops is not always recorded, and eyedrops are not discarded within 30 days of first use.</p> | <p>All medications are discarded and replaced when past their expiry date.</p> <p>The date of first use of eyedrops is recorded, and eyedrops discarded within 30 days of first use.</p> <p>90 days</p> |
| <p>Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review,</p> | <p>PA Low</p> | <p>Timeframes for completing an initial assessment, the development of a long-term care plan, and regular evaluation of resident progress towards identified goals had been met in all clinical files reviewed. Registered nurses are responsible for resident assessment, and a comprehensive range of hard copy clinical assessments are completed for each resident as part of the admission process, followed by six- monthly</p> | <p>36 residents do not have a current interRAI assessment.</p> | <p>All residents have a current interRAI assessment.</p> <p>180 days</p> |

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| <p>and exit) is provided within time frames that safely meet the needs of the consumer.</p> | | <p>reassessments.</p> <p>On the day of the audit visit there were 36 residents who did not have a current interRAI assessment. The service currently has two qualified interRAI assessors, with two other staff on the waiting list for assessor training. The clinical service manager (CSM) advised that two interRAI assessors had resigned in the past six months. Refer also to criteria 1.3.8.3.</p> | | |
| <p>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.</p> | <p>PA Moderate</p> | <p>All residents and family members interviewed expressed their satisfaction with care delivery.</p> <p>A review of clinical files identified numerous instances in which identified needs were not reflected in the resident's care plans. Refer tracer examples in 1.3.3. In another example, a resident was admitted few days earlier directly from hospital, with two medical conditions having necessitated their hospital admission. While there was good documentation in relation to the monitoring of one of these conditions since admission in the facility, with the exception of one brief entry in the progress notes, there was no evidence of the second condition being monitored, and it was not included in their plan of care.</p> <p>Three of the residents whose clinical files were reviewed had current interRAI assessments. Only some components of the assessment are in the clinical file, and this did not include the summary reports which are linked to care planning requirements. It was therefore difficult to identify whether the identified care needs were reflected in the resident's plan of care. The CSM confirmed that interRAI assessments were not informing care planning. Refer also to Tracers One, Two and Three in Standard 1.3.3.</p> <p>When wound documentation folders in two of the wings were reviewed, in over 50% of the cases it was unclear which wounds were still current. The CSM advised there were a total of seven pressure injuries in the facility. The incidence of pressure injuries is the highest of any UCG facility in all but one month of 2016. Medication errors are also higher than the</p> | <p>Documentation related to care delivery is incomplete, and there was insufficient evidence to confirm residents were receiving adequate and appropriate care.</p> <p>When a resident has a current interRAI assessment, assessment outcomes are not consistently reflected in the nursing plan.</p> <p>The doctor also expressed concerns about the standard of service delivery.</p> | <p>There is clear evidence that residents are receiving adequate and appropriate care and that care plans reflect the outcomes of interRAI assessments.</p> <p>90 days</p> |

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| | | <p>UCG average.</p> <p>One of the doctors who visits the facility at least weekly advised they were notified in a timely manner about changes in residents' conditions, but that their prescribed treatments/instructions were not consistently followed. The doctor stated that "there was a disconnect between registered nursing staff and caregivers", and that the "registered nurses were not leading care". The doctor met several months ago with registered nursing staff to express their concerns, and "there had been some recent improvement, but there was still a long way to go".</p> | | |
| <p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p> | <p>PA</p> <p>Moderate</p> | <p>The evaluation of long-term care plans is undertaken in a timely and comprehensive manner. Most short term care plans sighted were related to infections, and these had also been evaluated in a timely manner. At least 50% of the wound management documentation reviewed was incomplete. Although there was evidence of regular changes of dressings, and some photographs of wounds, few wounds had an associated short-term care plan. The form on which dressing changes are documented does not include wound treatment goals. It was difficult to establish which wounds were current at the time of audit. Refer also to criterion 1.3.3.3.</p> <p>In three instances a change in resident needs was not reflected in either their long-term care plan, or a short term care plan developed. One example of this was a care plan not being updated to reflect an instruction by the physiotherapist in relation to the use of a specific piece of equipment for mobilising the resident. Refer also to Tracers One, Two and Three, Standard 1.3.3.</p> | <p>When residents care needs change, care plans are not always updated to reflect this.</p> <p>Wound care evaluation is incomplete, and there are not always documented goals for wound management.</p> | <p>Each resident's care plan reflects their current care needs and documentation related to the management and evaluation of clinical conditions, such as wounds, is incomplete.</p> <p>90 days</p> |

Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.