The Ultimate Care Group Limited - Bishop Selwyn 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:

Legal entity:	The Ultimate Care Group Limited
Premises audited:	Ultimate Care Bishop Selwyn
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 6 August 2015 End date: 6 August 2015

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 69

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Ultimate Care Bishop Selwyn is situated in central Christchurch. The facility provides rest home and hospital services in 78 beds that can be used for hospital and rest home, as well as offering studio units for purchase. While these are outside the scope of this audit, the units can and are used for hospital and rest home due to their position within the facility. On the day of audit there were 33 hospital residents and 36 rest home residents. There has been no changes to the ownership or the facility since the previous audit.
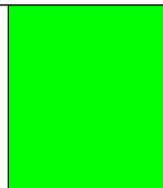
This unannounced surveillance audit against the Health and Disability Services Standards included a review of a sample of residents' files, interview of residents, relatives and staff, and observation of the environment. The sampling process included an in-depth focus on the care of two residents through their stay. Information gathered was used to determine the effectiveness of care provided and the organisation's systems.

Identified during this event is that there are dual use beds for rest home care (nine) and hospital care (one) in use currently at the facility. While this arrangement is of long standing and the management team understood it had been approved, there is no record of this. The report addresses the requirements for these conditions to be considered.

Two previous areas that required improvement have been fully addressed and no new areas for improvement were identified.

Consumer rights

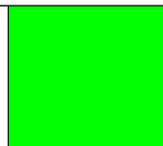|		
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.	██	Standards applicable to this service fully attained.

There is evidence that residents and families are notified of incidents when they occur. Detailed records are maintained recording communication with family members.

There is a current complaints register which is maintained by the facility manager according to the organisation's procedures for complaint management. There is easy access to the complaint management process. A complaint made to the Health and Disability Commissioner in 2014 was reviewed. This did not proceed to investigation and the facility was found to have provided appropriate nursing care, which was the subject of the complaint.

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.	██	Standards applicable to this service fully attained.

Bishop Selwyn is part of the Ultimate Care Group (UCG). The management team (a facility manager and clinical nurse manager both of whom are registered nurses), report to the wider organisation's senior management team.

Ultimate Care Group's quality and risk management system is well implemented at Bishop Selwyn. This includes the management of documents, reporting and recording of all adverse events, development of corrective actions, a comprehensive programme of internal audits and monitoring of the quality programme.

Human resources are managed following the UCG's systems and a review of personnel files confirms that the systems are implemented. Safe staffing levels are maintained at the facility.

As previously stated, dual use beds are utilised within the facility exceeding the number currently approved. The facility and clinical services manager both understood that appropriate approvals had been obtained and are managing the rostering of staff to the needs of all residents appropriately.

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.

The facility has fully implemented the interRAI assessment programme and other assessment tools. The clinical services manager (CSM) or the registered nurse (RN) completes the assessment, from which an initial individualised and detailed care plan is developed within three weeks, meeting a previous required improvement. Those reviewed were clear and reflected the resident's goals. Regular reviews occur to ensure the resident's assessed needs are met and the care plan is changed as required.

Short term care plans were developed when issues arose and these were closed out when resolved. Staff were observed during the audit providing service in a calm and respectful manner, reflecting the care plan content. This was also confirmed in family and resident interviews.
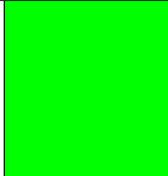
A general practitioner (GP) interviewed confirmed the facility provides a high standard of care and assessments and service delivery is appropriate and in line with treatment recommendations.

An activities programme is managed and implemented by a diversional therapist and an activities person, providing a variety of group and individual activities to meet the interests of the residents.

A medication system is implemented and the RN or care staff have been assessed as competent in the management of the medicines process. The GP completes a medication administration record for each resident which meets best practice guidelines. Medication administration was observed on the day of the audit demonstrating safe practice.

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 and reflects safe food practices and processes for storing and serving food. A recent nutritional review has occurred.

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.

There is a current building warrant of fitness for Bishop Selwyn. There have been no alterations to the facility since the last onsite audit.

The facility has studio apartments available under and occupation right agreement integrated within the main building. On the day of this audit there were 12 studios in which residents were receiving subsidised care. All are of an appropriate size and layout for the care being provided. They are located adjacent to rest home and hospital rooms and nursing stations. Staff receive appropriate training to provide responses in emergencies and to provides the level of support and supervision necessary to all residents at all times.

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.

UCG has a suite of policies and procedures on restraint minimisation and safe practice which are consistent with the required standard. The facility manager and clinical nurse manager are very clear that the facility does not practice the use of restraint and will utilise all alternatives to the use of restraints. This was observed during this audit.

When needed residents have appropriate mobility equipment which they use voluntarily and as when they choose. All appropriate documentation was in place to support the use of this equipment.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The clinical services manager oversees all aspects of the infection prevention and control programme, including collation of surveillance data. This is communicated to staff and the organisation at regular meetings and through an electronic reporting system. Trends are identified and systems are in place to minimise infections.

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	24	0	0	0	0	0
Criteria	0	56	0	0	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The Ultimate Care Group (UCG) has an appropriate complaint management policy and procedure which meets the requirements of the standards. There is an electronic register which is maintained at the facility and is current. This includes the type of complaint, the actions taken in response to the complaint and the status of the complaint. To date in 2015 there have been two complaints. Both have been responded to appropriately. One is still open and is being handled by the facility manager. The other complaint came verbally from the Canterbury District Health Board (CDHB) and was responded to within 48 hours, as requested by the portfolio manager. The complaint documentation was reviewed with the facility manager. No further follow-up was received from the DHB and they confirmed that the complaint was closed. Records of responses to complaints confirm that this occurs in a timely way and is respectful and comprehensive. When necessary the regional manager and/or the audit and compliance team from the UCG's head office are involved in complaint management. The regional manager reviews all complaints received on their monthly visits to the facility. During 2014 there was a complaint made to the Health and Disability Commissioner by a family member of a resident who died. The complaint was assessed and Ultimate Care's audit and compliance officer responded on behalf of the facility, which is consistent with the organisation's policy. A comprehensive file of the documentation requested and provided to the commissioner was reviewed during the audit. On

		23 December 2014 the Commission advised Ultimate Care that no further action would be taken and the complaint would not be investigated. The nurse assessor engaged by the commission noted in her assessment of her review that appropriate standards of nursing care and management had been provided.
Standard 1.1.9: Communication

Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There are guidelines for communicating with residents, relatives and visitors which sets out expected behaviours of staff. These were observed during the audit with staff heard addressing people in a respectful manner and residents being given time to answer. Residents and family members interviewed reported that staff ensured that they are understood and communication is respectful.

Open disclosure occurs according to the facility's policy. Incident reports record that a family member has been notified when this has been requested, and this is verified in family communication forms sighted.

The facility manager and clinical nurse manager (both of whom are registered nurses) were interviewed and verify that interpreter services are used for residents when 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 Ultimate Care Group Limited (UCG) is the governing body and is responsible for the services provided at Bishop Selwyn. The organisation has documented values, mission statement and philosophy, which were displayed in the entrance area of the facility and in a range of documents and plans. The service philosophy is in an understandable form and was available to residents and their family / representative or other services involved in referring residents to the service.

UCG has established systems in place which defines the scope, direction and goals of the organisation at UCG facilities, as well as the monitoring and reporting processes against these systems.

The manager at Bishop Selwyn has been in the position for four years after having worked in the sector five and a half years. Prior to this she had an extensive career at the DHB including in intensive care, nuclear medicine and holding management positions. The clinical services manager has been in the position for four years after having worked at Bishop Selwyn as a registered nurse (RN) and a senior RN since 2007.

Both managers are utilised by the organisation to support other facilities which are not meeting the organisation's standards. In the past year they have each spent some time in other facilities in the country assisting their colleagues to address issues and improve performance.

Support for the manager and clinical service manager is provided by a regional operations manager and the audit and compliance management team for UCG. |

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 | At interview with the manager and clinical services manager they described the process by which they provide cover for one another in temporary absence from the facility. During longer term absences a formal replacement is appointment to act in the vacant role with support from the remaining manager and UCG head office staff including the facility's regional manager and Audit and Compliance team members.

Staff members interviewed during the audit confirmed that these informal and formal arrangements have occurred and been clearly communicated to them. |
| Standard 1.2.3: Quality And Risk Management Systems

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The UCG Quality and Risk Management Plan is used to guide the quality programme and includes quality goals and objectives. Each facility has their own annual quality plan with objectives relevant to the ongoing activities in the facility. The January 2015 – January 2016 quality and risk management plan for Bishop Selwyn was reviewed with the facility manager. These objectives are consistent with the guidelines given in UCG's policy on the development of quality objectives and areas which are contributing to ongoing improvement at Bishop Selwyn.

The quality management system includes monthly quality improvement and staff meetings, internal audits with monitoring and reporting of the results of these through the UCG head office. 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.

Interviews with a range of staff members confirmed that they are involved in a range of quality related activities, quality improvement data is discussed at staff meetings and improvements and initiatives are known and understood within the facility.

The manager reported that they are responsible for providing weekly and monthly reports to UCG Head Office. Risks area reported on in these monthly reports and any variations are notified via these reports.

The clinical services manager is one of the three clinical services managers who is on the organisation's advisory group. This enables the facility to be closely involved in the process of review and development of policies and procedures. She was interviewed during the audit and provided copies of some recent policy documents she was involved in reviewing.

When indicated corrective action plans were raised to address any areas of concern or where improvements could be made. All completed internal audits which identified required improvements had corrective action plans developed. The incident and complaint reports also have sections for corrective action planning, and these are captured on the electronic GOSH reports. |

		Monitoring of the quality plans progress occurs through the head office teams monitoring of internal audits, GOSH reporting, and the annual unannounced internal audit conducted by the Audit and Compliance manager. This occurred at Bishop Selwyn in June 2015 and the corrective actions identified at the audit were sighted during this external audit. The three areas identified have been addressed and closed out by the audit and compliance manager.
		Review of a range of documents and records associated with the facility's quality and risk management system were reviewed. All are consistent with the implementation of the quality management system. Staff members interviewed confirmed that they receive information about collated data, receive detailed information about responses to individual events and trends when these are identified. They consistently reported that there is an effective flow of information in responses to individual events, trends and systemic issues and when outbreaks have occurred.
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	The adverse event reporting system provided evidence of a planned and co-ordinated process. Staff document adverse, unplanned or untoward events on incident/accident forms which are then reported on the UCG quality system through GOSH. They are filed in both residents' files and the facility register. All incidents were collated, reviewed and analysed at the monthly quality meetings and any corrective actions identified to improve service delivery and mitigate any risks. The GOSH incident register was reviewed for 2015 and a sampling of incidents from residents files were reviewed. These all followed the required process with all actions and outcomes recorded, including notification of families. Policy and procedures complied with essential notification reporting including health and safety, human resources and infection control. The manager demonstrated a clear understanding of what is required for essential notification reporting and the appropriate authorities to contact. (See also Standard 3 Infection prevention and control and 2014 Group A streptococcal outbreak.) Quality group meeting minutes and interviews with nursing and other staff confirm that there was clear communication of information during the outbreaks.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet	FA	The organisation has well described human resources management systems which include the recruitment and appointment of employees, orientation, training and on-going education, performance development and management and for associated good employment practices. A review of personnel files confirmed that all required documentation is maintained and recruitment and selection practices have been followed. Appropriate validation of annual practicing certificates is occurring, at employment and annually, both for employed staff and for contracted health professionals.

the requirements of legislation.		All practicing certificates were current to the time of the audit.
		There is a planned education programme which includes modules on restraint, the Code of Health and Disability Services Consumers' Rights (the Code), infection prevention and control, challenging behaviours and restraint minimisation, wound care, back care, nutrition and continence. Annual medication competencies are included where indicated. All registered nurses have current first aid certificates.
		All staff members interviewed reported that they received appropriate training to be able to do their jobs safely and well. A new RN who was currently involved with the induction process, reported she was feeling well supported and her training was comprehensive. She was to spend at least four days on specific shifts and had been given an induction pack to work through that covered all the necessary elements of a relevant programme. (She has worked as a caregiver at Bishop Selwyn in 2007 but her orientation /induction did not assume any prior knowledge of the organisation or its systems.) Staff members interviewed also reported that staffing levels are sufficient to be able to provide safe services to residents.
		All care givers complete ACE (Aged Care Education) training and certification programmes relevant to their roles. For the studio units where residents receive both rest home and hospital level care the staff assigned to these areas have and are more experienced staff members.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Twenty four hour registered nursing cover is provided.
		The manager completes all the rosters for the facility and uses the 'allocation of staff/duty rosters' tool which is used across UCG. This ensures the allocation for hours and staff meets the required levels to reflect the needs of the residents who are currently in Bishop Selwyn. This is sent off to the head office every Friday to show the level and skill mix rostered for the coming week.
		The manager completes all rosters ahead for a two week period and then rechecks just prior to each new week. If there are any queries the manager discusses these with the regional operations manager.
		The rosters showed sufficient staff levels and skill mixes appropriate to meet the current residents' needs.
		Records show that 2 dual beds have been approved to date. There are currently 15 dual use beds in use at Bishop Selwyn and the management team have understood that there has been approval for the dual use of these beds since they took up their roles. As noted the roster review demonstrates that there has been a consistent level of staffing to the meet the needs of all residents including those requiring rest home in the studios and the one studio resident who requires hospital level care.
		Bishop Selwyn have an experienced RN who is the team leader of the rest home. She works full time

| | | Monday – Friday morning and provides both clinical oversight and supervision for the rest home team, which includes another RN (employed but not yet commenced work), an experienced enrolled nurse / rest home coordinator and care givers). Most have completed or are completing their Level 2 Core competencies certificate, or are completing their Level 3 certificate.

The hospital wing has full time RNs, 24 hours a day with experienced care givers, all of whom have completed, or are completing their Level 3 Core competencies certificate. |
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| 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 | Ultimate Care Bishop Selwyn has contracted and implemented a blister pack system and medicines are reconciled into the facility by the RN monthly. Policies and procedures for medication management include each health professional's responsibility in relation to medicine prescribing, administration, reconciliation, dispensing, storage and disposal.

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 that are competent to perform the function. The records reviewed were legible and dated. Prescription records consistently included the reason for pro re nata (prn) medications. When an alteration occurs the GP updates the record in the facility as sighted in records reviewed, and all medications are reviewed at least three monthly.

One RN 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 area in the room for a medication fridge and temperatures were recorded and within recommended guidelines.

There was one resident assessed as being suitable to self-administer inhaler medications, complying with the facility's policies and procedures, including administration record monitoring addressing a prior required improvement. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management

A consumer's individual food, fluids and nutritional needs are | FA | On admission residents have a personal nutritional profile and a mini nutritional assessment completed. The profile covers food preferences and dislikes, any modified equipment required, any special dietary needs, food allergies or intolerances and whether or not they require assistance with feeding. An interview with the cook explains her role as ensuring meals are prepared in line with the dietitian |

| met where this service is a component of service delivery. | | approved menu. The menu has a four weekly cycle with winter and summer variations. Menu recommendations have been implemented, as explained by the cook. Residents' meeting minutes confirmed the residents enjoy the meals provided and this is verified in resident and family interviews.

Modified meals and assistive equipment is provided. Meal orders are updated as tastes and needs change and records of these are sighted. One resident who is vegetarian has these needs met, and staff are observed preparing this separate from other preparations.

Food preparation occurs in the on-site kitchen. All food procurement, storage, production, preparation, transport, delivery and disposal follow safe guidelines and meet all legislative requirements. There is evidence that stock rotation occurs. Records were sighted for fridge, freezer and food temperatures, and all are within recommended guidelines. |
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| Standard 1.3.6: Service Delivery/Interventions

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The facility's RN documents appropriate interventions on the resident's care plan, based on prior completed assessments, the interRAI assessment tool and resident and family input.

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.

GP assessments sighted were detailed on the medical clinical forms in the integrated residents' files and the subsequent intervention included on the residents' care plans. The GP confirmed interventions were always implemented by the facility staff following appropriate assessments by the RN. |
| Standard 1.3.7: Planned Activities

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | A social activity profile was developed by the diversional therapist (DT) or activities person following admission to the facility in files reviewed. An activity plan was developed following the completion of the resident's long term care plan. Progress notes were observed to be completed monthly and report on progress relevant to the resident's individual activity programme and social interactions. Evaluations are completed at the time of the care plan review.

The general activity programme includes a range of activities including church services, arts and crafts, outings and word games. Residents and family interviewed were very happy with the content and variety of activities provided.

An activities calendar is displayed in each resident's room each month and daily activities on a white board in the lounge. Outings are planned twice a month for both rest home and hospital residents. |

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All care plan reviews are the responsibility of the RN. During interview the CSM 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. Progress toward meeting outcomes is included in the review or evaluation. Reviews are three monthly.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are documented UCG protocols for the management of waste and hazardous substances which are implemented at Bishop Selwyn. Staff members receive training in these, particularly the housekeeping (cleaning and laundry) staff members. The protocols are on display in the laundry and in cleaners' cupboards. All cleaning and laundry chemicals are in original labelled containers and are stored safely when not in use. Hazardous substances are clearly labelled. At interview with staff members they confirmed that they have access to adequate supplies of personal protective equipment and information and training as noted.
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 manager advises there have been no alterations to the building since the last audit. The current building Warrant of Fitness is displayed in the main entrance and expires on 29 June 2016. In studio apartments where rest home level care is provided (nine) and one where hospital care is provided, the apartments are of a sufficient size to accommodate any mobility equipment the residents may require. Where needed rooms and bathrooms have been refurbished to better meet a resident's needs for safety and comfort as they have transitioned to a higher level of care. In particular the bathroom of the ORA resident receiving hospital level care has been upgraded and modified to make it fully accessible for them and staff while they assist the person. All ORA units where (rest home and hospital) care is provided are integrated within the facility. The studio where hospital care is provided is close to the nurses station and adjacent to two hospital level rooms. Studio units where rest home care is provided are similarly close to the staff station where the RN / team leader is based who has clinical oversight of the rest home. (See also 1.2.8)
Standard 1.4.3: Toilet, Shower, And Bathing Facilities	FA	There are sufficient numbers of toilets, showers and bathing facilities to meet people's needs. Studio units all have their own ensuite bathrooms which include, toilets, wash hand basins and showers. All hospital rooms have ensuites which include toilet and shower. All rest home rooms have wash basins

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		and toilets, four of these rooms have their own shower; six rooms have shared showers. Additionally there are three communal showers and three communal toilets within the rest home area.
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	All rooms are appropriate for the use of residents. Studio units are large 'bed/sit' rooms with an ensuite and garden access. Rest home and hospital rooms are appropriately sized to accommodate beds and personal furniture, as well as the provision of care when this is required.
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	There are two main dining rooms, one for rest home and one for hospital level residents, with additional recreation rooms throughout the facility. During the audit visit residents were seen to be using all the available communal areas throughout the day. This included for pre-arranged group activities with the diversional therapy team as well as individuals and groups using the rooms for their own activities. The dining rooms are of a sufficient size to accommodate all residents and their mobility equipment during meal times.
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 facility is clean and well maintained as observed on the day of the audit. UCG's systems for monitoring the effectiveness of cleaning and laundry are implemented by the housekeeping staff members, who were interviewed. Internal audits which are completed systematically include the cleaning and laundry functions, and sampling of these confirmed that this annual monitoring has been completed, with results reported through the GOSH system to UCG's head office. Any variances require corrective action and follow-up.
Standard 1.4.7: Essential, Emergency, And Security Systems	FA	Included in the training programme implemented at Bishop Selwyn is fire safety and evacuation, emergency response procedures and essential systems for civil defence emergencies. Sampled personnel files and other records reviewed confirm the information reported by staff and the managers.

Consumers receive an appropriate and timely response during emergency and security situations.		That is that all staff receive clear and well set out guidelines at orientation and during annual refresher training. There are periodic reminders during staff meetings and interviewed staff stated that they consider themselves to be prepared for an emergency. Throughout the facility there is appropriate signage for security (times that doors are locked / unlocked) and emergency meeting locations. Locations for emergency and fire safety equipment are clearly indicated. The resident who receives hospital level care in a studio unit has had an electronic call bell installed in their room, consistent with other hospital level rooms and residents. As noted in standard 1.2.8 there are appropriate staffing arrangements for the provision of subsidised care to residents in studio units and each of these 12 units is integrated within the facility. These units have electronic call bells connected to the RH nurses' station. There is an approved evacuation plan for 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 has been constructed so that all rooms have external windows which allow natural light and ventilation. There is centrally controlled heating and the facility was maintained at an even and comfortable temperature. Windows in all bedrooms and communal rooms can be opened to allow in fresh air. The facility is surrounded by gardens which are visible through the windows and also provide a pleasant view through the many windows. All windows in residents rooms are of normal dimensions and provide sufficient natural light for an environment which residents reported they enjoy and appreciate.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The CSM is responsible for infection surveillance and for reporting the data, analyses and recommended actions to the organisation's electronic system on a monthly basis. Surveillance data is provided at monthly staff meetings, quality meetings and the RN/EN meeting. This includes all infections. A recent 'group A streptococcal' outbreak gained high praise from the Canterbury medical officer of health for the management and control of the outbreak. Short term care plans are observed to be used for residents with an identified infection. Information regarding each infection is transferred onto an infection control surveillance form in the facility's main office. This information is collated to identify trends and treatments are documented. Examples were sighted and the information showed that infection rates overall are low.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	UCG has a suite of policies and procedures to guide facilities in the management of restraints and enablers, should these be required by residents. The facility manager, who is also the restraint coordinator, reports that they have philosophy of no restraint use at Bishop Selwyn. There are systems and processes in place so that should restraints or enablers be required they can be used. Other staff members interviewed were familiar with the restraint policies, the voluntary use of enablers and the processes to be followed should either be required. The restraint approval group meets annually while there are no restraints in use, and any restraint use is reported through the quality group and at staff meetings. The most recent meeting minutes of the restraint group were reviewed. Currently there are no enablers in use at the facility either. There are a small number of residents who use mobility devices, but the emphasis is on minimisation if at all possible and this is actively explored. One resident was observed to be safely using a manual wheelchair safely without the need for a lap belt due to the configuration of the foot plates to suit the resident's needs.

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.

No data to display

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.

No data to display

End of the report.