

The Ultimate Care Group Limited - Ultimate Care Cambridge Oakdale

Introduction

This report records the results of a Provisional 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 Cambridge Oakdale

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 17 September 2015 End date: 18 September 2015

Proposed changes to current services (if any): Sale and purchase of Oakdale Rest Home Cambridge, (the service) by The Ultimate Care Group

Total beds occupied across all premises included in the audit on the first day of the audit: 35



Executive summary of the audit

Introduction

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

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

General overview of the audit

This provisional audit was conducted to assess Oakdale Rest Home's compliance with the Health and Disability Services Standards and its contract with the Waikato District Health Board. The audit also considered the level of preparedness within The Ultimate Care Group Ltd (UCG) to purchase this service from Kingswood Health Care Ltd. Oakdale Rest Home continues to provide safe and effective rest home and specialist dementia level of care for up to 47 residents.

There were no areas identified as requiring actions for improvements. Areas of best practice are described in the report.

This audit report is based on combined evidence from documentation reviewed on site, observations, and interviews with management, staff, residents, family/whanau, a general practitioner and the dispensing pharmacist.

Consumer rights

Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. Staff received ongoing education on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights.

There were no residents who identified as Maori residing at the service at the time of audit. The service provider reports there are no known barriers to Maori residents accessing the service. Services are planned to respect the individual culture, values and beliefs of the residents.

Staff communicate effectively with residents and their family/whanau. Residents, family members and external health providers interviewed, stated that communication is one of the strengths of this service. There was evidence that residents, families and other parties are provided with full and frank information in accordance with the principles of open disclosure. Appropriate written consents have been obtained.

The service continues to manage complaints effectively. Information on how to raise concerns and complaints is provided to new residents and their families on entry, and whenever there is a need. The complaint register was up to date and recorded the complaints received since the previous audit in January 2015. Each of these complaints had been acknowledged, investigated and resolved satisfactorily. There have been no known complaints to the Office of the Health and Disability Commissioner.

Organisational management

UCG have a transition plan and the necessary skills/experience to effectively manage the service.

All residents at Oakdale Rest Home are continuing to receive safe services that are well managed, planned and coordinated. This is evidenced by high resident and family satisfaction and endorsements from other health service providers who were interviewed on the days of this audit.

Quality and risk management systems were effective and integrated across all areas of service delivery. The service was managing all health and safety and risk matters in accordance with known safe best practice and legislation. There have been no serious

adverse events or other events that required notification since the previous audit. The event reporting system was well established, effective and known by staff.

Recruitment, selection and management of staff meets the requirements of these standards and New Zealand legislation. All staff are attending regular ongoing education and training in subject areas that are specific to the residents being cared for.

There were sufficient numbers of suitably qualified and experienced staff on site 24 hours a day seven days a week in the rest home and the dementia unit.

The resident records were securely stored. No private information was publicly displayed.

Continuum of service delivery

The entry criteria for the service is clearly documented and communicated to the potential resident, family/whanau and referring agencies. If entry to the service is declined, a record is maintained and the potential resident and/or their family/whānau are referred to a more appropriate service.

Residents receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. Each stage of service provision is undertaken by suitably qualified and/or experienced staff who are competent to perform the function. The processes for assessment, planning, provision, review, and exit are provided within time frames that safely meet the needs of the resident and contractual requirements. Evaluation of care is consistently documented at least six monthly meeting a previous required improvement.

The needs, outcomes, and/or goals of residents are identified through the assessment process and documented to serve as the basis for care planning. The care plans reviewed described the required support and/or intervention to achieve the desired outcomes. The provision of services and interventions was consistent with, and contributed to, meeting the residents' needs.

In the dementia unit the admission assessment and integration into the facility is an area of excellence with evidence of improved resident outcomes.

Resident support for access or referral to other health and/or disability service providers is appropriately facilitated or provided. Staff identify, document, and minimise risks associated with each resident's discharge or transfer.

The service provides a planned activities programme that reflects the service's 'Spark of Life' philosophy of care. In the dementia unit an individualised resident scrap book showed improved resident outcomes and is an area of excellence for the service. The activities are planned and provided to develop and maintain skills and interests that are meaningful to the residents.

Staff responsible for medicine management are assessed as competent to perform the function for each stage they manage. Areas requiring improvement to ensure all medications given are signed as given and that there is a documented assessment process for self-administered medications have now been addressed.

The menu has been reviewed by a dietitian as suitable for the older person living in long term care. Residents and family reported satisfaction with the meals and choices provided.

Safe and appropriate environment

The building warrant of fitness is current. The interior refurbishments completed 12 months ago, such as new flooring, furniture and the newly constructed dementia unit, are in as new condition.

Cleaning and laundry services continue to be provided to a high standard. Chemicals were stored appropriately.

Emergency and disaster equipment and resources are available on site and staff are maintaining their first aid certificates. Fire systems and training for staff on emergency management and fire evacuations is ongoing.

All building regulations, fire safety, emergency and security standards are met.

Residents and their families reported high satisfaction with the environment.

Restraint minimisation and safe practice

The service is maintaining a restraint free environment in accord with its philosophy. Policy and processes meet the requirements of the restraint minimisation and safe practice standard. Staff training in relation to this standard is mandatory and all staff are attending an education update at least annually.

Infection prevention and control

There is a managed environment which minimises the risk of infection to residents, service providers and visitors. The service has a clearly defined and documented infection control programme that is reviewed at least annually. There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the service. The documented policies and procedures for the prevention and control of infections reflect current accepted good practice and relevant legislative requirements. These policies and procedures are practical, safe, and suitable for the rest home and dementia level of care.

Surveillance for infection is conducted monthly with agreed objectives, priorities, and methods that have been specified in the infection control programme. Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to staff and management in a timely manner. The infection control committee is incorporated into the three monthly health and safety meetings.

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	45	0	0	0	0	0
Criteria	0	93	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) was displayed throughout the facility. New residents and families reported that they were provided with copies of the Code as part of the admission process.</p> <p>One registered nurse (RN) and five caregivers during interview and observation demonstrated staff knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents' rights. In the dementia unit staff were observed working in a calm manner that de-escalated and redirected the residents with cognitive impairment, when necessary.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The residents' files reviewed had consent forms signed by the resident or by the enduring power of attorney (EPOA). Staff act on the information in advance directives, where these have been made. The caregivers interviewed demonstrated their ability to provide information that residents require in order for the residents to be actively involved in their care and decision-making. Staff acknowledged the resident's right</p>

		to make choices based on information presented to them. Staff also acknowledged the resident's right to withdraw consent and/or refuse treatment, with the staff in the dementia unit demonstrating good knowledge on management of challenging behaviours.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	The family/whanau and residents interviewed report that they were provided with information regarding access to advocacy services. Contact details for the Nationwide Health and Disability Advocacy Service was listed in the client information booklet, with the brochure available at the entrances to the service. Education was conducted as part of the in-service education programme.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	There are no set visiting hours and family/whānau are encouraged to visit at any time. The family/whanau reported there were no restrictions to visiting hours. Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme.
<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 procedures meet the requirements of this standard, the provider's contract with the district health board (ARC contract) and Right 10 of the Code.</p> <p>The policy contains references to advocacy and the organisation's quality system, resident's rights, and resident/family meetings.</p> <p>Review of the complaints register and interview with the nurse manager revealed that the complaints received since the previous audit have been acknowledged, investigated and satisfactorily resolved with all parties concerned. The majority of these were not from residents or their families. Residents and their families confirmed they are advised on entry to the facility of the complaint processes and the Code.</p> <p>Complaint forms are readily accessible and/or displayed in various locations throughout the facility. Staff attend regular education on the Code of Rights, including complaints processes.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The family/whanau of the dementia unit and rest home wing residents and residents interviewed report that the Code was explained to them on admission and was included as part of the admission pack. Nationwide Health and Disability Advocacy service information is also included in the admission pack with brochures available at the entrance.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has six shared rooms, with all these rooms having privacy screening. The family/whanau interviewed reported that their relative is treated in a manner that shows regard for the resident's dignity, privacy and independence. The residents' files reviewed indicate that residents received services that are responsive to their needs, values and beliefs. The family/whanau and residents interviewed reported high satisfaction with the way that the service meets the needs of their relatives.</p> <p>Observations of provision of care in the dementia unit and review of the residents' files, confirmed residents receive services in the least restrictive manner to meet the independence and wishes of the residents.</p> <p>The family/whanau and the one general practitioner (GP) interviewed did not express any concerns regarding abuse or neglect. The family members report they are 'absolutely amazed' by the staff who treat their family members with respect and dignity. The families of residents living in the dementia unit reported that all staff were excellent at intervening with any potential escalating behaviour of the residents.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are no residents who identify as Maori at the time of audit. The clinical manager reported that there are no barriers to Maori accessing the service. The caregivers interviewed demonstrated a good understanding of services that are commensurate with the needs of the Maori resident and importance of whanau. There is Maori consultation with kaumatua when the service opened the dementia unit.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The residents' files reviewed demonstrated consultation with families on the resident's individual values and beliefs. The family/whanau reported they were consulted with the assessment and care plan development. The caregivers interviewed demonstrated good knowledge on respecting each resident's culture, values and beliefs. The cultural needs of a resident who has different cultural and religious beliefs had their specific needs recorded.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The staff files reviewed had job descriptions and employment agreements that had clear guidelines regarding professional boundaries. The family/whanau residents interviewed reported they were very happy with the care provided. The families expressed no concerns regarding breaches in professional boundaries and all reported high satisfaction with the caring, calming and patient manner of the staff.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice is observed, promoting and encouraging good practice. Examples included policies and procedures that are linked to evidence-based practice, regular visits by the GP, links with the local mental health services and palliative care services. The DHB care guidelines for aged care are utilised. The gerontological nurse specialist visits residents as required to consult regarding residents who are referred for additional care advice. The caregivers who work in the dementia unit have completed or are enrolled in education specific to specialist dementia care. The service has implemented the 'Spark of Life' philosophy for the care of residents with dementia and this is observed to be an area of excellence in the dementia unit. The service has a trained 'Master practitioner' in the implementing of the 'Spark of Life' philosophy. The philosophy is still to be implemented in the rest home wing.</p> <p>There is regular in-service education and staff access external education that is focused on aged care and best practice. The caregivers interviewed reported that they were 'very satisfied' with the relevance of the education provided, especially around the management of challenging behaviours, as this has resulted in improved service</p>

		delivery. The family/whanau and residents expressed high satisfaction with the care delivered.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Staff demonstrate that they understand the principles of open disclosure and discussed the ways in which residents and their families' right to full and frank information is upheld. Family members and the GP confirmed they are kept informed of the resident's status, including details of events which may have affected the resident. Evidence of open disclosure is documented in the family communication sheets within each resident's file, on accident/incident forms, in the complaints documentation and in the residents' progress notes. All interviewees reported that communication is excellent and one of the strengths of the service. There is currently one person for whom English is a second language. Staff described their attempts to learn and use the resident's native language and other ways they have communicated with previous residents who do not speak or understand English.</p> <p>The ARRC requirements related to this standard are met.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Telephone interview with a senior management person of the Ultimate Care Group (UCG) who are the prospective provider, confirmed that the company has an established and robust governance and management structure and is suitably prepared to purchase and operate another aged care facility. The organisation understands the processes and success factors for taking over an existing service. The UCG operate 16 other aged care facilities and have an in depth understanding about the NZ aged care sector, legislation, regulations, professional standards and contract requirements related to the operation of these services. Transition from the existing policies and systems to UCG systems is planned to occur over a three month timeframe. UCG intend to maintain the status quo in the short term (ie, no immediate changes to the current scope of services - rest home and dementia care, or with staffing or the environment).</p> <p>The nurse manager at Oakdale Rest Home has been in the position since 2006 and has previously held management roles in other aged</p>

		care facilities. The manager maintains her nursing portfolio and clinical skills and knowledge by attending regular professional development and education in subject areas related to management and care of older people. The service meets the contractual (ARCC) requirements.
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	FA	<p>On the days of audit there were 35 of the potential 47 beds occupied. There were four dementia beds and eight rest home beds unoccupied due to a number of recent resident deaths. One resident with a long term disability is under the age of 65 years.</p> <p>Temporary cover during the manager's planned absences is provided by the onsite clinical manager with oversight from management staff in the other facilities owned by the same group. This is confirmed by the clinical manager who has been acting manager in the past. The role was included in the clinical manager's job description.</p> <p>The service meets the requirements of the ARCC.</p>
<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>	FA	<p>The quality system and quality monitoring methods continue to be effectively maintained. The system is moderated by the quality group who respond to the Quality Improvement Plan, and provide feedback to the facility staff. Minutes of staff meetings revealed that quality data, such as accidents/incidents, complaints, infection rates, results from internal audits and feedback from resident/family meetings and resident plan reviews were considered regularly. Where improvements are required these were discussed, actions agreed and implementation was monitored by the manager.</p> <p>The proposed purchaser/provider UCG Ltd stated there will be a staged and smooth transition from the current systems to UCGs systems over a three month period from the date of hand over.</p> <p>The risk management and occupational health and safety documentation contain indicators for risk and a comprehensive risk assessment matrix. The sighted hazard register was current. The nominated Health and Safety Officer meets with the Health and Safety group every six months and all staff meetings included health and safety</p>

		<p>discussions.</p> <p>Policies, forms, and quality and risk systems are consistent across the current provider Kingswood Health Care. The group continues to identify, update and implement systems and processes it determines are the best/most effective methods in each of its three facilities. Staff interviewed stated that they understood and continued to be involved in quality and risk management activities. The service meets the requirements of the ARCC.</p>
<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>The service has clearly documented and known processes for reporting, recording, investigating and reviewing adverse events. Review of incident/accident records and analysis and interview with the manager confirmed that all events are being reported, recorded and reviewed, as soon as possible. The trending and monitoring of these continues to be based on comparing data with data from the previous year to determine a benchmark average. The service is maintaining a low rate of falls, despite admission of a 'frequent faller' in the dementia unit (refer to the tracer example in Standard 1.3.3). There have been no medicine errors reported for 18 months.</p> <p>There have been no serious events requiring notification. Review of the incident documentation and interview with the manager and clinical manager confirmed that investigations and corrective and remedial actions are implemented where necessary. Staff confirmed they are informed of incidents immediately and/or at handover and that these are discussed at staff meetings. The service meets the requirements of the ARCC.</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>	FA	<p>Personnel records and staff interviews confirmed that all the registered nurses (RNs) have current practising certificates and any other professional qualifications have been validated prior to employment occurring. There is evidence that prospective staff are recruited according to the service policies using formal interviews, police checking and referee checks, all of which were sighted in the sample of personnel records reviewed. New staff are inducted according to a documented</p>

		<p>orientation programme which includes training in essential emergency systems on day one and subject areas specific to different staff roles.</p> <p>Staff learning and development occurs in a planned way. Review of individual staff files showed that staff who are authorised to administer medicines continue to be competency assessed annually. This was confirmed by interview, review of two RNs and four staff training records and observations of medicine rounds. All staff continue to attend an eight hour study day once a year. These contains mandatory education topics (e.g., restraint minimisation, sexuality and intimacy, challenging behaviour, infection prevention and control, privacy, safe chemical use, informed consent, consumer rights, wound care, open disclosure and documentation). The study days are planned and presented at least three times a year to enable all staff to attend. All staff are now trained in the 'Spark of Life' programme which promotes independence and maintaining quality of life for older people. The majority of care staff are engaged in or have completed the Aged Care Education (ACE) programme which includes modules on working with older confused people who may present challenging behaviour. Only staff who are engaged in the dementia education programme work in the dementia unit. All staff have previously attended training in understanding and caring for people with dementia related conditions with a regional dementia specialist. Other in house education is scheduled and attended at regular intervals as required. Staff also attended external courses related to their roles and scope of practice. The manager continues to attend at least eight hours of education related to the role of manager. The service meets the requirements of the ARCC.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There are documented guidelines about the level of suitably qualified/skilled staff for the number of residents and their needs. Review of the staffing rosters and interviews with staff, residents and family members revealed that there are sufficient nursing and care staff rostered on all shifts in the rest home and the dementia unit to meet contractual requirements; however, care staff are concerned with the workload in the rest home now that the number of care staff hours have been reduced because of lower resident numbers. The concerns relate to the high demand from a few residents who require additional supervision and care. There is also a gap in the number of household</p>

		<p>staff (cleaning, laundry and kitchen staff/cooks) which is placing some staff under pressure to perform dual roles for some shifts. Resident safety is not compromised but this may not be sustainable in the long term.</p> <p>There are sufficient activities coordinators hours allocated to meet the specific needs of residents in the dementia unit. A resident advocate/support person continues to be employed to transport residents to outpatient and community appointments and provide for other personal support needs. A building and grounds maintenance person is onsite 32 hours per week and there are allied health professionals who are contracted to deliver services as required (eg, podiatrist and physiotherapist). The service meets the requirements of the ARCC.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>A review of records, interview with the clinical manager and documentation confirmed that information is entered into each resident's integrated file in a timely manner. Records reviewed were current and legible.</p> <p>Current residents' old notes and archived records are stored in a secure room. These were observed as organised and dated.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Oakdale Rest Home provides rest home and dementia level care. The service had an enquiry book that logs enquiries for admission. The residents are required to have an assessment for the appropriate level of care. The entry criteria, assessment and entry process is clearly documented and communicated to the potential resident and family/whanau.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>When admission is required to the acute care hospital, the service utilises the DHB's transfer form/envelope. The referral process documents any risks associated with each resident's transition, exit, discharge, or transfer. This includes expressed concerns of the resident and family/whānau and a copy of any advance directives. With the</p>

		<p>transfer form/envelope, the RN reported that the service also provided a copy of any other relevant information, such as medication chart. A file of a resident reviewed with a recent admission to the acute care hospital evidenced that the transfer to and from the hospital was effectively managed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Most of the medicines are supplied by the pharmacy in a robotic administration system. The medicines that are not pre-packed, such as liquid medicines, are individually supplied for each resident. The medicines and pre-packed medicine sheets are checked for accuracy by the RN when delivered. The pre-packed medicines and the signing sheets are compared against the medicine prescription. The GP conducts medicine reconciliation on admission to the service and when the resident has any changes made by other specialists.</p> <p>Safe medicine administration was observed at the time of audit in each area. All records were accurately completed closing a previous area of required improvement.</p> <p>The medicines and medicine trolley are securely stored. The medicine fridge is monitored for temperature, with the sighted temperatures within medicine storage guidelines. The controlled drugs were stored in a locked draw in the dispensary room. The controlled drugs were signed out by two staff at each administration and a weekly stock count was recorded in the controlled drug register. The additional six monthly controlled drug stocktake and reconciliation was recorded. The pharmacist conducts an external audit of the medicines systems. The pharmacist was interviewed during the audit and confirmed a strong relationship with the service. He also undertakes reconciliation of robotic packs, provides in-service training and has formal three monthly meetings with management regarding any medication queries.</p> <p>All the medicine charts sighted had prescriptions that complied with legislation and aged care best practice guidelines. Each medicine was signed by the GP and had the required level of documentation to allow safe administration of the medicines. The prescriptions were legible, recorded the name, dose, route, strength and times for administration. The medicine charts recorded the regular, short course and pro-re-nata</p>

		<p>(PRN – as required) medicines for each resident. When medicines were discontinued, these were signed and dated by the GP. The medicine charts sighted had a current photo of the resident and recorded any medicine related allergies. Sample signature verification was recorded for all staff who administer medicines. All of the medicine charts were reviewed by the GP in the past three months.</p> <p>Medication competencies were sighted for all staff that assist with the medicine management; this included the RNs and some senior caregivers.</p> <p>The RN reported that there was one rest home resident who self-administers inhalers, in accordance with the facility's policy and procedures, addressing a previous area requiring improvement.</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>	<p>FA</p>	<p>The current menu was reviewed by a dietitian as suitable for the older person living in long term care. All residents report satisfaction with the food and food services.</p> <p>Residents were routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets had these needs met.</p> <p>The dementia unit has a kitchenette, where residents and staff assist with some baking activities. There is food and fluids available 24 hours a day in the dementia unit.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines. Fridge and freezer recordings were undertaken daily and met requirements. All foods sighted in the freezer were in their original packaging or labelled and dated if not in the original packaging. Evidence was seen of all kitchen staff having completed safe food handling certificates and ongoing education.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk</p>	<p>FA</p>	<p>The clinical manager reported that they have not declined entry to any potential residents who have an appropriate needs assessment. The clinical manager reported that if entry to the service was to be declined</p>

<p>to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>the referrer, potential resident and where appropriate their family/whānau, would be informed of the reason for this and of other options or alternative services.</p> <p>The admission agreement contained information on the termination of the agreement. The admission agreement documented if the resident's needs changed and if the service can no longer provide a safe level of care to meet the needs of the resident, they would be reassessed for the appropriate level of care. The manager reported residents requiring hospital or psychogeriatric care have been reassessed and transferred to a more appropriate facility. Evidence in a recent file verified this occurs.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The service has implemented interRAI assessments, although not all residents have been assessed using the electronic tool. The service was still using the organisational wide paper based assessment tools during the transition. The service uses assessment tools for skin integrity/pressure area risk, falls risk, monitoring of behaviours and nutritional assessment. The care plans sighted reflected the assessed needs of the residents. The assessment processes sighted in the residents' files reviewed covered the residents' physical, psycho-social, cultural and spiritual needs.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>All the care plans reviewed were individualised and reflected the resident's individual needs. The files of both the residents reviewed using tracer methodology had appropriate care plans that identified the resident's needs and care requirements. The residents' files and care plans demonstrated service integration. The files had one main folder that contained the medical information, nursing assessment, care plan, routine observations, activities, therapies, family correspondence and specialist consultations.</p> <p>The residents and family/whanau interviewed reported that the staff have excellent knowledge and care skills. The GP interviewed expressed satisfaction with the care provided.</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 desired outcomes.</p>	<p>FA</p>	<p>The provision of services and interventions were consistent with, and contribute to, meeting the residents' assessed needs, and desired outcomes. The care plans reviewed were individualised and personalised to meet the assessed needs of the resident. The care was flexible and focused on promoting quality of life for the residents. All residents and family/whanau interviewed reported satisfaction with the care and service delivery.</p>
<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>	<p>FA</p>	<p>The activities programme covered physical, social, recreational and emotional needs of the residents. There were diversional therapy, activities, social and cultural assessments sighted in the residents' files reviewed. The activities coordinators report they use the assessments to develop an activities programme that is meaningful to the residents. The residents were included in activities at the care facility and as part of the wider rural community. Feedback was sought from residents at the residents' meeting and during activities. The two activities coordinators reported that they gauge the response of residents during activities and modified the programme related to response and interests. Both the activities coordinators from the dementia unit and the rest home sections gave a number of examples of how the activities programme, which has its philosophy based on the 'Spark of Life' principles, has seen improved communication, interaction and reduction of challenging behaviours of the residents.</p> <p>The introduction of a photo scrapbook for every resident in the dementia unit demonstrated the excellent standard of activity participation incorporating the spark of life programme.</p> <p>The two files reviewed of the residents living in the dementia unit had a summary of activities and diversional therapy over a 24 hour period. The families are encouraged to participate in the recreational, exercise and reminisces therapies with their relative. The families reported a high level of satisfaction with the care and therapy provided.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All the care plans sighted were developed, reviewed and evaluated at least six monthly. This previous required improved has now been addressed.</p> <p>The files of the residents living in the dementia unit were reflective of the residents' needs. One of these files reviewed had a short term care plan for wound care.</p> <p>Where progress was different from expected, the service responded by initiating changes to the care plan or by use of short term care plans for temporary changes. Short term care plans were sighted in the files reviewed. One file reviewed had a short term care plan for a wound.</p> <p>The residents and family/whanau interviewed reported high satisfaction with the care provided at the service.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The service has a number of local GPs that provide medical coverage to the residents. The residents were able to maintain their own GP if available. The GP arranged for any referral to specialist medical services when it was necessary. The residents' files reviewed had appropriate referrals to other health and diagnostic services. Referrals were sighted for consultations with general medicine, dermatology, neurology, surgery, mental health, and radiology and cardiology services. The GP interviewed reported that appropriate referrals to other health and disability services were well managed at the service.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Policy and procedures describe safe and appropriate disposal methods for all types of human and domestic waste. These also include standards about chemical labelling, the use of protective clothing and equipment and reporting of spills incidents.</p> <p>Chemical Material Safety Data/information is available and accessible for staff. The sighted Hazard Register is being kept current. Review of staff training records and interview with cleaning, laundry and care staff confirmed that regular training and education on the safe and appropriate handling of waste and hazardous substances occurs.</p>

		<p>Visual inspection throughout the facility and observations of staff during both audit days revealed that protective clothing and equipment (eg, goggles/visors, gloves, aprons, hats, footwear, and masks) are being provided and used appropriately.</p> <p>The few hazardous substances on site (eg, petrol, paint and turpentine) are correctly labelled and stored safely.</p> <p>The ARRC requirements related to this standard are met</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The systems in place for ensure the physical environment and facilities are safe and fit for their purpose, are effective. There are sturdy and correctly positioned handrails in corridors, showers and toilets to promote safe mobilisation. All external areas inspected are being maintained as safe and secure and there is appropriate seating and shade. Visual inspection and review of documents confirms that the facility is in good repair and that all medical equipment is checked and calibrated regularly (for example, sphygmomanometer, sitting scales and the hoist). This was confirmed by review of documentation and the calibration/performance verified stickers in place on medical equipment. The current Building Warrants of Fitness expires on 30 June 2016.</p> <p>UCG Ltd state there is no immediate plan to make changes within the physical environment.</p> <p>The ARRC requirements related to this standard are met</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	<p>Twenty nine of the 31 rest home bedrooms have attached ensuite bathrooms with a shower, hand basin and toilet. There is a separate shower room and toilets for the two residents whose rooms do not have individual bathrooms. The dementia unit has three toilets and two showers for a maximum of 16 residents. Each ablution area is being maintained in good working order and there is suitable heating in each bathroom. Hot water temperatures at all water outlets are tested monthly. Temperatures are being maintained at just below 45 degrees Celsius.</p>

		The ARRC requirements related to this standard are met
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Observations on the days of audit and interview with staff revealed that the configuration of ensuite bathroom doors compromises movement and manoeuvrability of the sling hoist if this is required in the rest home bedrooms. Otherwise residents have sufficient space to move around safely and for one or more staff to assist them.</p> <p>The families of residents who are sharing bedrooms in the dementia unit expressed satisfaction with the bed configuration and said they have come to understand why sharing rooms can be calming and beneficial for the confused elderly.</p> <p>The ARRC requirements related to this standard are met</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The rest home has a large communal lounge which is also used for activities. The lounge space is furnished in a way that enables residents who do not want to participate in group activities to do their 'own thing' without interference; this was observed on both audit days. The dining room and lounge are within easy walking distances to bedrooms. Residents interviewed confirmed they use their rooms or external areas if they want privacy or quiet times. Staff expressed a desire for more private spaces for families to spend time with their loved ones, especially if the resident is ailing or palliative. The dementia unit has good sized dining area with kitchenette/servery and the lounge is separated by a wall partition. All furniture is being maintained in good condition and is safe and suitable for the consumer group.</p> <p>The ARRC requirements related to this standard are met</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The laundry and cleaning policies detailed the tasks and standards for safe and hygienic practice. These included procedures for handling used and soiled laundry and an itemised cleaning schedule which listed the cleaning chemicals to be used in each area.</p> <p>Cleaning and laundry systems are safe and effective and there have</p>

		<p>been no complaints or issues since the previous audit. Currently the laundry and cleaning staff are splitting their duty hours between caregiving and kitchen cooking which they are also suitably skilled and experienced to do. There have also been situations when there is no back up cleaner on the weekends. This is in response to reduced resident numbers and a staff vacancy but this is not ideal in terms of infection control and best safe practice and will not be tenable in the long term.</p> <p>The internal audit programme monitors the effectiveness of the cleaning and laundry services. The laundry and cleaning staff interviewed are experienced and very knowledgeable about their equipment/tools of trade, and the cleaning chemicals they are in contact with. They attend regular in service education and stated they were well supported by the chemical supply company that visits monthly. Chemicals are labelled and stored safely and securely in locked storage areas when not in use. Chemical safety data sheets are being kept current and are located in the laundry. Effective processes and appliances are in use for the disposal of soiled water/waste (eg, sluice disposable bed pans, plastic bags, and chemical cleaners). Hand washing and hand sanitising units are conveniently located and readily accessible.</p> <p>The ARRC requirements related to this standard are met</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The evacuation scheme was reviewed and approved by the NZ Fire Service in October 2014 shortly after the new fire alert and suppression system was installed. Staff engaged in a desk top fire evacuation exercise in May 2015. All night staff, permanent afternoon care staff, senior caregivers and RNs are maintaining first aid certificates.</p> <p>Personnel records and internal audit records contained evidence of ongoing staff training in emergency preparedness. Emergency procedures are included in new staff orientation and staff knowledge is tested regularly. Interviews with a sample of nurses and care staff from all shifts and auxiliary staff demonstrated knowledge and understanding about what to do in emergencies.</p> <p>The facility is kept secure by ensuring that all external doors and windows are locked and checked at night and that visitors are directed</p>

		<p>to enter and exit by the front door only.</p> <p>There is sufficient food, water and medical and personal care supplies stored on site to meet the needs of 47 residents for at least three days. The contents of the sighted civil defence kit is checked regularly. Additional blankets for warmth and alternative energy supplies (eg, barbeque, torches and batteries) are also kept on site. In the event of a power outage, emergency backup lighting system is powered by battery. There is no generator on site to provide mains electricity.</p> <p>The call bell system installed throughout the facility functions effectively. Residents interviewed stated that staff responded to all calls within an acceptable timeframe and this was confirmed by observations on audit days.</p> <p>The ARRC requirements related to this standard are met</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>The internal heating systems are powered by electricity. There are panel heaters in the corridors, heat pumps in communal areas and heaters that can be individually controlled in each bedroom. There are working heaters in all bathrooms. The home has sufficient doors and external opening windows for ventilation. All bedrooms have good sized external opening windows with security stays installed. Residents and family members and staff interviewed confirmed that internal temperatures and ventilation is comfortable during summer and winter months.</p> <p>The ARRC requirements related to this standard are met</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The manager (RN) holds the role of infection prevention and control coordinator. The job description for the infection control coordinator role is clearly defined. There are clear lines of accountability for infection control matters at the service through the quality meetings, and relevant information is provided to the board. The health and safety meeting is incorporated into the infection control committee. The infection control coordinator provides a report to the management team monthly.</p> <p>The annual review of the infection control programme, through review of</p>

		<p>the policies and procedures, was conducted in the past 12 months.</p> <p>The service has clear policies about staff, residents and visitors suffering from, or exposed to and susceptible to, infectious diseases. Staff reported that they did not come to work if they were unwell. There was a notice in the staff room about different infections, signs and symptoms and exclusion periods from the workplace. Notices are placed at entrances at times of the year when there was an increased risk of infections, to ask visitors not to visit if they are unwell, or had been exposed to others who are unwell. The infection control coordinator reported that residents were asked to stay in their room if they have an infection risk. There was sanitising hand gel throughout the service for residents, visits and staff.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator attends ongoing education and demonstrated current knowledge of infection prevention and control best practice. The infection control coordinator reported they can access external advice from the previous infection control coordinator, the GP, product supplier, DHB and Ministry of Health services as required. The Aged Care Association and DHB clinical nurse specialist provides support, which includes current information on infection prevention and control and wound management. Infection control is discussed at the three monthly health and safety meetings.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The service uses policies and procedures that were developed by a specialist infection prevention and control advisory service. The Aged Care Association provides updated and current information on infection prevention and control. The infection control coordinator demonstrated sound knowledge on infection prevention and control. As observed at the time of audit staff also demonstrated good infection prevention and control practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control</p>	FA	<p>Infection control education is provided by the infection control coordinator, who has maintained their knowledge of current practice.</p>

<p>to all service providers, support staff, and consumers.</p>		<p>The in-service education programme contained education and attendance sheets for infection prevention and control education sessions. The infection prevention and control education is part of the annual compulsorily in-service education. These sessions were referenced to current accepted good practice.</p> <p>Informal education is provided as required to residents and their family/whānau on infection prevention and control. The infection control coordinator gave examples of encouraging residents with fluids and personal hygiene for a resident with recurring urine infections.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The service conducts monthly surveillance for infections, with three monthly analysis of the data reviewed at the health and safety meetings. The service uses standardised definitions of infections that are appropriate to the long term care setting.</p> <p>The infection and surveillance data reviewed for the past year showed an overall low rate of infections. For one spike in infection this was explained as a recurring urinary tract infection that has now been resolved. The evaluation and analysis of the infection surveillance data was documented in the health and safety meeting minutes.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Interview with the clinical manager/restraint coordinator provides evidence that Oakdale Rest Home's restraint philosophy and practice has adapted to meet the philosophy and approach of its parent company (Kingswood Healthcare) which is to maintain a restraint free environment. There have been no restraints used since April 2014 and there were no enablers in use.</p> <p>The assessment, consent and monitoring documents described processes that would meet this standard in the event that a restraint intervention was required. The Restraint Minimisation and Safe Practice and Enabler Use policy contains definitions that are congruent with this standard. The policy states the only restraint interventions authorised for use are bed rails and lap belts and clearly describes methods for avoiding or minimising the use of restraint. It designates a restraint coordinator, and clearly describes the processes for evaluations and</p>

		<p>review and ongoing staff education.</p> <p>Review of a sample of staff files and training documents confirmed that staff engage in ongoing education. This included managing challenging behaviour, use of de-escalation techniques and preventing the use of restraint.</p> <p>There is also an emergency restraint policy which authorises a RN to initiate an emergency restraint before a GP assessment.</p> <p>The ARRC requirements related to this standard are met</p>
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Specific results for criterion where corrective actions are required

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

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

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

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

No data to display

End of the report.