The Ultimate Care Group Limited - Kensington Court 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 Kensington Court
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 3 February 2016 End date: 3 February 2016
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	56

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 Kensington Court in Nelson is certified to provide rest home and hospital level care for 63 residents. On the day of this spot surveillance audit there were 56 residents; 34 rest home residents and 22 hospital residents.

The governing body is Ultimate Care Group Limited. The Facility Manager and Clinical Services Manager oversee the day to day management of the facility, and are supported by the organisation's management group, one of whom was present on the day of the audit.

The audit against the Health and Disability Services Standards and the providers contract with the district health board, included observation of the environment, interviews with the management team and staff, review of documentation and interviews with residents and their families.

The two areas identified as requiring improvement at the previous audit have been addressed. No other areas were identified as requiring improvement.

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.

Staff demonstrated respect when interacting with residents. Communication with families following any event or change in the condition of a resident is timely and effective.

An easily accessed and responsive complaints process is in place. Complaint forms are readily available. The facility manager is responsible for complaints and an up to date complaints register is maintained. All complaints reviewed were resolved satisfactorily within the required timeframes.

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.

The Ultimate Care Group Limited is the governing body for the facility and is responsible for the service provided at Ultimate Care Kensington Court. The vision statement, values, quality objectives, quality and risk management plan, indicators and projects reflect a commitment to providing quality care to residents and are reviewed regularly. Systems are in place for monitoring the services provided including monthly reporting by the facility manager to the Ultimate Care Group Head Office.

The facility is managed by a suitably qualified and experienced manager who is well supported by the organisation.

There are policies and procedures on human resources management and all health professionals have the required current practising certificates. There is a comprehensive education programme in place.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. Staff interviewed were happy working at the facility and showed a commitment to the residents' care and wellbeing.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.

A registered nurse (RN) develops a detailed care plan based on the interRAI and other assessments to guide staff in service provision and reviews these within recommended timeframes.

Observation of care staff, review of residents' notes and resident and family interviews, confirmed that all staff provide individualised care that reflects the residents' needs and outcomes. A general practitioner (GP) was interviewed during the audit and confirmed the facility provides a high standard of care and his recommendations and treatments are carried out. The GP visits three monthly if the resident is assessed as clinically stable and more frequently is required. Two residents were reviewed in detail using tracer methodology confirming the facility's systems are consistently being implemented.

An activities programme is planned and implemented by the activities person and it was confirmed by residents and family members that this is age appropriate and of interest to them. Individual activity plans now reflect the resident's individual interests meeting a previous shortfall.

Policies and procedures are in place for all stages of medication management. A robotic pack medication system is in use for the facility. The medication administration process was observed during the audit confirming safe practice occurs. Documented medication records are completed and reviewed by the resident's GP. The previous required improvement regarding faxed medications has now been addressed. Controlled medicines are secure and meet recommended guidelines for storage and monitoring.

A dietary profile is completed for each resident on admission and any special dietary needs are met. Personal likes and dislikes are catered for. The kitchen service is managed from within the facility by the cook who is supported by kitchen staff. A nutritional review of the menu has occurred in the past 12 months and, as observed, the meals reflected the menu. Appropriate monitoring of food procurement, transportation and storage of food occurs.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

The building has a current warrant of fitness which expires in March 2016.

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.

Ultimate Care Kensington Court is a restraint free environment. The use of enablers is voluntary with efficient processes in place for the review and monitoring of their use.

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 enrolled nurse 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 staff meetings, and relevant information is provided to the organisation via their electronic system.

Results of surveillance are documented, analysed and a report included at staff and management meetings. This includes specific recommendations for minimising 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	17	0	0	0	0	0
Criteria	0	39	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 service has a complaints process that meets all the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). All complaints are given to the facility manager who then ensures the relevant process is followed. There have been no complaints received so far this year. A review of the five complaints in the register from the previous six months was completed. These reflect adherence to the appropriate process and were all resolved satisfactorily. Staff have a clear understanding of what constitutes a complaint and they report and document all complaints received, whether they are in writing or verbal. They support all residents in making complaints if needed.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	FA	There are procedural guidelines for communicating with residents, relatives and visitors which sets out expected behaviours of staff, and observations during the audit reflect these. Staff were observed interacting with residents in a way that is respectful and positive. Residents and family members interviewed verified that staff ensure that they are understood and communication is full and frank. Open disclosure occurs according to the facility's policy. This was evident on incident reports reviewed that show family members are notified and all follow up is conducted in an open process with full documentation. A family/whanau contact sheet is kept in personal files with all discussions recorded. The facility manager (FM) confirms no residents currently require an interpreter service, but the DHB service is

communication.		able to be accessed if needed at any time.
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 service provided at Ultimate Care Kensington Court. The Quality and Risk Management Plan 2016 reviewed includes a vision statement, core values, quality objectives, quality indicators and quality projects and scope of service. Also reviewed were documented values, the mission statement and the group's philosophy. The service philosophy is in an understandable form and is available to residents and their family/representative or other services involved in referring clients to the service. These are all reviewed annually. The facility manager and clinical services manager (CSM) provide weekly and monthly reports to the governing body which were reviewed. Regular teleconferences are held with the regional manager and two monthly visits provide regular support for management. The current manager, who has been in the role for seven months, has previous experience in a number of senior management roles and human resources in the commercial sector over the past 15 years. The organisation has provided additional support with mentoring, the availability and support from the onsite audit and compliance manager, and a longer handover period from the relief manager to ensure the transition to the aged residential sector is managed with as much support as needed.
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 national Ultimate Care Group (UCG) Quality and Risk Management Plan, which is then individualised to each facility, is used to guide the quality programme and includes relevant quality goals and objectives. The UCG quality and risk electronic management systems are in place and Ultimate Care Kensington Court's specific quality and risk plan is used to plan quality projects and respond to any corrective actions that are raised. The quality improvement theme for this year is 'predictable outcomes'. There is an 'Ultimate Care Group Clinical Advisory Group' (CAG) in place. This comprises of two clinical leads, clinical services support, business analyst, the chief operating officer, the interRAI advisor and the audit and compliance manager who are responsible for reviewing clinical issues and policies and procedures following feedback from each of the UCG sites. There is an internal audit programme in place which feeds into the quality reporting system in the monthly reports along with all other quality indicators including complaints, adverse events, infections, health and safety and restraint. Review of quality improvement data evidences the data was being reported to UCG Head Office via the intranet as well as to staff via various meetings. Quality committee and staff meetings are held monthly and there is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in those meetings. The quality committee was made up of the representatives from all areas of staff. Minutes kept from the last meeting were sighted and any staff who were unable to attend were required to read and sign those minutes. It is recommended that a specific agenda item on pressure injuries is included on the monthly agenda to reflect the

		current emphasis on the management and reporting of these across the sector. Month by month graphs of various clinical indicators are produced to inform staff of the trends and progress. All staff interviewed reported they were kept informed of quality improvements and were involved in implementing the quality improvement activity. Other areas reported on include occupancy, staffing and HR, property/environmental issues, financial and general comments. The residents have regular meetings and any concerns raised at this forum are subsequently raised at the quality meeting. Relevant standards were identified and included in the policies and procedures manuals. Policies and procedures reviewed were relevant to the scope and complexity of the service, reflected current accepted good practice and referenced legislative requirements. Policies / procedures were available with systems in place for reviewing and updating regularly, including a policy for document reviews and a document control policy. All old policies are archived appropriately. Care staff interviewed confirmed the policies and procedures provided appropriate guidance for service delivery and they were advised of new policies / revised policies via handover and meetings. A Health & Safety Manual is available that included relevant policies and procedures. There is a hazard reporting system in use nationally and the facility hazard register was reviewed and is up to date.
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 reviewed provided evidence of a planned and coordinated process. Staff document adverse, unplanned or untoward events on an incident/accident form which are then recorded on the UCG electronic quality system. They are then filed in both the resident's file and the facility register. All incidents are reviewed and analysed at the monthly quality meetings and any corrective actions identified to improve service delivery and mitigate any risks raised. Documentation for the previous month was reviewed and all reports followed the required process with all actions and outcomes recorded, including notification of families. Policy and procedures comply 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. Documentation from a recent outbreak demonstrated all relevant processes were followed.
Standard 1.2.7: Human	FA	There are well described human resources management systems.

Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		Written policies and procedures in relation to human resources management were reviewed. The skills and knowledge required for each position within the service are documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with reference checking, criminal record vetting, interview questionnaires, employment agreements, completed orientations and competency assessments. Professional qualifications were validated during recruitment. A copy of the annual practising certificate (APC) for all qualified nurses employed are kept on their personnel file. All files reviewed had the appropriate qualifications recorded. A copy of all current APCs for the pharmacists, podiatrist, GPs and allied health professionals are kept in a separate file which was also reviewed. Annual medication competencies were included where needed. There is a comprehensive planned education programme which included modules on restraint, the Code, infection prevention and control, challenging behaviours, wound care, back care, nutrition and continence. All registered nursed have current first aid certificates. Four registered nurses are interRAI trained and the CSM is on a waiting list to complete this. The orientation programme is comprehensive and includes all the required elements. Documentation on staff files records when all training, including orientation, has been completed. All staff members interviewed reported they had received appropriate training to be able to do their jobs safely and well.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The manager and the CSM complete all the rosters for the facility and use the standard UCG safe staffing rostering tool. This ensures the allocation for hours and staff meets the required levels to reflect the needs of the residents who are in the facility at the time. The roster are completed two weekly and show the level and skill mix rostered for those weeks. The current rosters were sighted for all areas of the facility and these met the requirements.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that	FA	Routine medications 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. In the hospital wing a standard small supply of medications are available for urgent situations. The medicines and pre-packed medicine sheets are checked for accuracy by the RN when delivered. The GP conducts medicine reconciliation on admission to the service and when the resident has any changes

complies with current legislative requirements and safe practice guidelines.		made by other specialists. Safe medicine administration was observed at the time of audit. All records were accurately completed. Medications were seen to be securely stored, and at appropriate temperatures. Controlled medications were checked according to medication guidelines, including pharmacist checks. 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 (PRN – as required) medicines for each resident, including urgent prescriptions meeting a previous required improvement. 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, except those of recent admissions. Medication competencies were sighted for all staff that assist with the medicine management; this included the RNs. There were no residents who self-medicate, although there are processes in place should this occur.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The current menu was reviewed by a dietitian as being suitable for the older person living in long term care. The same menu is used throughout the organisation. If there are changes to the menu these are recorded and referred to the dietitian at the next review. The cook in charge of the kitchen has been at the facility for over eight years and has had a recent food hygiene education update. All residents interviewed reported satisfaction with the food and food services. Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets had these needs met. There is food available 24 hours a day for those who wish to snack at night. All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. A cleaning schedule with assigned tasks is completed each shift and the kitchen is observed to be clean, tidy and organised. Food temperatures, fridge and freezer recordings are undertaken daily and meet requirements. All foods sighted in the freezer were in their original packaging or labelled and dated if not in the original packaging.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Services are being delivered according to information in resident's individualised care plans. Short term care plans are being developed for short term problems, such as skin tears and decreased mobility, pain and urinary infections. Progress notes reviewed demonstrated that care and support was consistent with the identified problems, personal goals and interventions, as described in the care plans. Carers informed they report any concerns about a resident, such as a change in their condition, both in the progress records and to RNs, and this was confirmed. Any untoward issues that arise are managed through the short term care planning process, which includes detailed interventions. Residents spoke highly of the level of care and support provided and consistently stated that all of their needs are being met.
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	On admission a personal profile is completed for each resident. A detailed and individualised activity plan is developed and updated during review, meeting a previous required improvement. A range of activities are planned for each month and copies of the monthly activity schedules showed that options are varied. The monthly plan is in each resident's bedroom in a large print format. The diversional therapist during interview described the planning and involvement of residents in preparing the programme. Two other activity people assist with the programme and regular meetings are held to ensure the programme is suitable for all residents. Those interviewed are comfortable with the activities available, and say they like the variety and confirmed there is no compulsion to attend, or participate if they are in the lounge during activity time. Residents who wish are assisted to undertake activities on a one to one basis and a record is retained of this.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Evaluation of both short and long term care plans is occurring in recommended timeframes with detailed outcomes/goals included. Both residents and family are consulted and are informed when changes are identified, this is confirmed during interviews and in family communication forms. Information is being included in progress note updates and changes are being made to interventions when indicated. Staff interviewed state they are consulted prior to evaluations. The interRAI tool is in use for all residents.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment	FA	The manager advised 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 in March 2016.

and facilities that are fit for their purpose.		
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Although this was not part of the surveillance audit requirements, the DHB asked for assurance that the provider had a current emergency plan with a focus on the ability to remain as self-sufficient a possible in the event of an extreme emergency that may preclude access to usual emergency services. All plans and emergency supplies were checked on site and these meet the necessary requirements asked for. There are sufficient supplies of water, adequate arrangements for power and sufficient supplies stored to be able to be self–sufficient for a period of time.
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 enrolled nurse 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 staff meetings, and relevant information is provided to the organisation via their electronic system. Results of surveillance are documented, analysed and a report included at staff and management meetings. An electronic system is used by the organisation. This includes specific recommendations for minimising infections
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The facility has a restraint free environment. There is currently only one enabler in use. The register with the required documentation was sighted including the assessments and consents along with evidence of ongoing three monthly reviews and evaluation. A relevant monitoring process was in place and these were all completed. The restraint coordinator reported the facility has recently introduced new mattresses with perimeter sides to reduce the use of enablers needed, such as bed rails.

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.