

# The Ultimate Care Group Limited - Karadean Court Lifecare

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## 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:

<b>Legal entity:</b>	The Ultimate Care Group Limited
<b>Premises audited:</b>	Ultimate Care Karadean
<b>Services audited:</b>	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	Start date: 12 April 2016    End date: 13 April 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	50



# Executive summary of the audit

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

## General overview of the audit

Ultimate Care Karadean is certified to provide hospital and rest home level care for up to 53 residents. On the day of this unannounced surveillance audit there were 50 residents at the facility. Within this number are four young persons with a disability (YPD).

The facility is in Oxford, Canterbury. 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.

The audit against the Health and Disability Services Standards and the provider's 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.
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Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. There was evidence that residents, families and other parties are provided with full and frank information in accordance with the principles of open disclosure.

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, one is ongoing.

## 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.
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The Ultimate Care Group Limited is the governing body for the facility and is responsible for the service provided at Ultimate Care Karadean. The vision statement, values, objectives, quality and risk management plan and quality projects reflect a commitment to providing quality care to residents and are reviewed regularly. Systems are in place for monitoring the services provided, including regular 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 had 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 reported they were happy working at the facility and showed real 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.
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A RN develops a detailed lifestyle 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. Care plans now reflect all health professional's recommendations meeting a previous required improvement. A general practitioner (GP) was interviewed during the audit and confirmed the facility provides a good standard of care and his recommendations and treatments are carried out. There was evidence in files reviewed that the GP visits three monthly if the resident is assessed as clinically stable, and more frequently if required. Two residents reviewed in detail, including one with a pressure injury, and additional files sampled confirmed the facility's systems are functioning as planned.

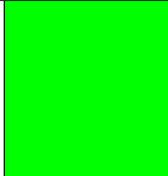
An activities programme is planned and implemented by the diversional therapist and this is age appropriate and of interest to residents. Individual activity plans reflect the resident's individual interests.

Policies and procedures are in place for all stages of medication management. A blister 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 medication records 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 reflect 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.
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Easily accessed, safe outside areas are provided for residents. The building has a current building warrant of fitness. There have been no alterations since the last audit.

## 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.
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The facility has a philosophy of not using restraints. There was one enabler in use at the time of the audit. There are policies and procedures in place, which meet the requirements of these standards. All staff receive training in the facility's procedures.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The clinical services manager holds the role of infection prevention and control coordinator. 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, including analyses and recommendations.

## 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)
<b>Standards</b>	0	17	0	0	0	0	0
<b>Criteria</b>	0	43	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Ultimate Care Groups (UCG's) complaints policy meets the requirements of Right 10 of the Code of Health and Disability Services (the Code). This is provided to all new residents on entry to the service, and included at induction for all new staff. There is an annual staff training session that includes complaints management.</p> <p>The complaints register is maintained online by the FM. There have been 19 complaints registered in the past year, 18 have been resolved and one is ongoing. The required timeframes have been met. The issues raised were managed appropriately, and no specific trends identified. Staff interviewed demonstrated a clear understanding of their responsibilities for reporting any concerns raised by residents and family.</p>
<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 demonstrated that they understand the principles of open disclosure. Residents, family 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 within each resident's file. All interviewees reported that communication is excellent.</p> <p>Incident and complaints reports confirmed that open disclosure occurs.</p> <p>At the time of this audit there were no residents who required interpreter services to ensure effective communication. But the facility manager (FM), clinical services manager (CSM) and staff during interview demonstrated their understanding of the organisation's processes for obtaining these services should they be</p>

		required.
<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>The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the service provided at Ultimate Care Karadean. The Quality and Risk management Plan 2016 reviewed includes a mission statement, values and objectives, key indicators and quality projects and the scope of service at this facility. A review occurs annually. The facility manager (FM) and clinical services manager (CSM) provide weekly and monthly reports to the head support office which were reviewed. Regular teleconferences are held with the regional manager and two monthly visits provide regular support for management.</p> <p>The current manager, who has been in the role for four years, has previous experience in a number of senior management areas and as an RN has clinical experience. The organisation provides ongoing support from regional manager, and audit and compliance manager.</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 Ultimate Care Group Quality and Risk Management Plan, which is then individualised to each facility, guides a quality programme and includes relevant quality goals and outcomes. The company utilises an electronic risk management system incorporating Ultimate Care Karadean's specific quality projects and is used to action any corrective actions that are raised.</p> <p>Quality improvement is one overall objective of the company and encourages each facility to continually focus on improving systems and resident outcomes. Resident and staff report that they are included and encouraged to have input into quality improvement.</p> <p>The organisation has a clinical leadership model in place so all clinical leaders in the group connect with each other at a professional forum regularly. This group is responsible for reviewing clinical issues and policies and procedures following feedback from other facilities within the organisation.</p> <p>An internal audit programme is in place and included in the electronic quality reporting system. Monthly reports as well as quality indicators including complaints, adverse events, infections, health and safety and restraint are documented into the system.</p> <p>A review of quality improvement data evidences that information is provided by the electronic system as well as to staff through monthly meetings.</p> <p>The quality committee comprised of representatives from all areas of staff. Minutes from the previous three months meeting were sighted and any staff that were unable to attend were required to read and sign those minutes. A specific agenda item on wounds and pressure injuries included the two recent pressure injuries at the facility. Monthly graphs of various risks are produced to inform staff of occurrence and outcomes. All staff interviewed reported they were kept informed of quality improvements and were involved in implementing the</p>

		<p>quality improvement activity.</p> <p>Residents and family reported that there are regular meetings and any concerns raised are acted on or reported to management. Evidence of meeting minutes showed these issues are also included at quality and risk management meetings.</p> <p>Policies and procedures in place are current, regularly reviewed and reflect evidence based practices.</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>There is an incident and accident reporting policy which includes the essential notifications and statutory and regulatory reporting. The requirement to report pressure injuries of category 3 under section 31 of the Health and Disability services (Safety) Act has been added to the policy as part of the 2016 review.</p> <p>Adverse events are reported and recorded on the electronic reporting system, including two pressure injuries. A reporting form is available for staff which is collated by the CNM. The FM will enter this onto the electronic system. An analysis of data shows no specific patterns or trends identified. Staff confirmed that they would report events using the reporting forms. They understand the importance of reporting events as soon as possible.</p> <p>The general practitioner (GP) reported that he is notified of events in a timely manner. Residents and family reported that they are also notified of events if they occur.</p> <p>There are two pressure injuries in the facility and the FM and CNM have reported these according to new guidelines.</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>Ultimate Care Group has overall responsibility for human resources (HR) management. The FM manages the roster and will discuss with the organisation any HR shortfalls and requirements. Professional registration is sighted and recorded in all health professionals' files.</p> <p>A comprehensive recruitment, induction, orientation and appraisal programme is in place, including documented interviews, reference checks and ongoing performance reviews.</p> <p>The 2016 training programme includes monthly in-service education sessions. Content reflects service needs and standard requirements. In 2015 the monthly education sessions were consistently attended by at least 50% of staff at each session.</p> <p>There is a staff member on each shift who has completed first aid training.</p> <p>Four of eleven RNs, including the CSM, are trained in the interRAI assessment programme.</p> <p>Staff, residents and family interviewed confirm staffing levels are adequate.</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>The roster was reviewed and reflects the facility's skill mix policy. There are sufficient RNs and care staff on all shifts over 24 hours. These are in line with recommended standards. These staff exclude the FM and the CSM, who also share the on-call rolls for the facility.</p> <p>Staff during interview report that staffing levels are sufficient and there are casual staff to cover during sickness and other leave. This was confirmed during interviews with family and residents.</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>Routine medications are supplied by the pharmacy in a blister pack administration system. The medicines that are not pre-packed, such as liquid medicines, are individually supplied for each resident or as stock for hospital residents. 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. All records were accurately completed.</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 are stored in a locked safe in the medication cupboard. Controlled medications on site at the time of the audit are being recorded in line with medicine care guidelines.</p> <p>All the medicine charts sighted had prescriptions that now comply with legislation and aged care best practice guidelines meeting a previous required improvement. 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. 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.</p> <p>There were no residents who self-administers although there are policies and procedures in place should this be required.</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. If there are changes to the menu these are recorded and referred to the dietitian at the next review. A diary records any changes. All residents interviewed reported great satisfaction with the food and food services.</p> <p>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.</p> <p>There is food available 24 hours for those who wish to snack at night.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. 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. Evidence was seen of all kitchen staff having completed safe food handling certificates.</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>Lifestyle care plans reviewed were individualised and developed from the interRAI assessment tool, reflecting the resident's individual needs. Recommendations from other disciplines is also included meeting a previous required improvement. The files of the residents reviewed using tracer methodology had interRAI care plans that identified the residents' needs and care requirements, including the resident with a PI. 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>Residents and family/whānau interviewed reported that they are consulted at the time of care plan reviews and staff delivered services in line with their wishes. 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>Services are being delivered according to information in resident's individualised care plans.</p> <p>Short term care plans are being developed for short term problems, such as skin tears and decreased mobility and 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.</p> <p>Care staff informed that they report any concerns about a resident, such as a change in their condition, both in the progress records and to the RN, and this was confirmed in documentation reviewed and interview with the RNs.</p> <p>Residents spoke well of the level of care and support provided and consistently stated that all of their needs are</p>

		being met. The GP during interview confirmed that his interventions ordered are always implemented.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>On admission a personal profile is completed for each resident. A detailed and individualised activity plan is developed and updated during review. The activity plan for individual residents is included in the interRAI care plan. A range of activities are planned for each month and copies of the monthly activity schedules show that options are varied. There are two diversional therapists sharing the role of activities. One during interview reported that options for group activities are discussed at residents meetings, confirmed in the minutes.</p> <p>Residents interviewed are happy with the activities available. They 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 of this is retained.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Evaluation of both short and long term care plans is occurring in recommended timeframes with detailed outcomes/goals included. The six month review is in line with the six monthly interRAI assessment and the lifestyle plan is updated. Both residents and family are consulted and are informed when changes are identified. This was confirmed during interviews and via a signature on the base of the care plan.</p> <p>Information is being included in progress notes and changes are being made to interventions on care plans when indicated. Staff interviewed stated they are consulted prior to evaluations. There is evidence of this in multidisciplinary review forms.</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 FM 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 June 2016.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in</p>	FA	<p>The infection control (IC) co-ordinator is the CSM and was interviewed.</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 do not come to work if they are unwell.</p>

<p>accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>Notices are placed at entrances to ask visitors not to visit if they are unwell, or have been exposed to others who are unwell. There was sanitising hand gel throughout the service for residents, visitors and staff.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>A documented restraint and enabler use policy is in place and meets the standard requirements. At present there is one respite resident with bedrails as an enabler in use at the facility. All monitoring is in line with the facility's policy and procedure guidelines. Staff interviewed demonstrated knowledge in enabler and restraints and confirmed their training in relation to this.</p>

## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.