# The Ultimate Care Group Limited - Ultimate Care Oakland

## Introduction

This report records the results of a Certification 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** The Ultimate Care Group Limited

**Premises audited:** Ultimate Care Oakland

**Services audited:** Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical

**Dates of audit:** Start date: 11 December 2017 End date: 12 December 2017

**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:** 54

# 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 |
|  | 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 Group operates Ultimate Care Oakland, an aged care facility in central Tauranga. Ultimate Care Group owns aged care facilities across New Zealand, some with co-located retirement villages, as is the case with Ultimate Care Oakland. There are national offices with an executive team of business and experienced aged care managers who provide support to these facilities.

Ultimate Care Oakland provides rest home, hospital (geriatric and non-acute medical) and residential disability care for people with either intellectual or physical disabilities for up to 85 residents. Twenty beds in the facility are currently not in use. This leaves 65 beds available. The service is managed by a facility manager and a clinical services manager. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family members, managers, staff, contracted allied health providers and a general practitioner.

The provider has fully attained all audit and contract requirements. There are no areas for improvement identified.

## Consumer rights

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

The Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

A complaints register is maintained with complaints resolved promptly and effectively.

## 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. |

Business and quality and risk management plans include the organisation’s scope, direction, goals, values and mission statement. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents’ records are maintained in using an integrated electronic and hard copy files.

## Continuum of service delivery

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

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents’ needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents’ files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by one diversional therapist and two recreation/activities officers, provides residents with a variety of individual and group activities and maintains their links with the community. The local taxi van is used for outings while the facility van is undergoing repairs.

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

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

## Safe and appropriate environment

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

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

The organisation has implemented policies and procedures that support the minimisation of restraint. At the time of audit, five residents were using restraints. No residents were using enablers.

A comprehensive assessment, approval and monitoring process with regular reviews occurs. The use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

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

The infection prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board, an external advisor, and the group’s Clinical Advisory Panel. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken and data is analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## 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 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 101 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Ultimate Care Oakland has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent form including for photographs, outings, invasive procedures and collection of health information.  An initiative within the facility, to implement advance care planning was well established. All files reviewed had a documented advance care plan in place using Ultimate Care’s format for these. Establishing and documenting enduring power of attorney requirements and processes for residents who are unable to consent is defined and documented where relevant in the resident’s file. Staff demonstrated their understanding by being able to explain situations when this may occur.  Staff were observed to gain consent for day to day care on an ongoing basis. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service and the contact details of how to access the service were displayed at all entrances to the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.  Staff were aware of how to access the Advocacy Service. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.  The facility has unrestricted visiting hours and encourages visits from residents’ families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints and concerns policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to access this process.  The complaints register reviewed showed that 11 complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Communication with complainants was respectful. Action plans showed any required follow up and improvements have been made where possible. The facility manager is responsible for complaints management, and follow up. She demonstrated a thorough knowledge of the responsibilities of her role.  All staff interviewed confirmed a sound understanding of the complaint process and what actions are required of them in their particular roles.  There have been no complaints received from external sources since the previous audit. The facility is involved in a complaint made to the Health and Disability Commissioner (HDC) by the family of a former resident relating to a health professional involved in the resident’s care. The facility is complying with all requests from the HDC since they were first contacted on 16 August 2017. At the time of the audit this complaint was still being assessed by the Commissioner. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents and family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on how to access the advocacy services, how to make a complaint and feedback forms. Resident satisfaction surveys evidence satisfaction by residents and families on the information provided regarding being informed of their rights. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents, families and the results of a recent satisfaction survey, confirmed that residents receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and in discussion with families and the general practitioner (GP). All residents have a private room.  Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident’s abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | There are two residents in Ultimate Care Oakland at the time of audit who identify as Māori. Evidence verifies staff support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. Interviews with staff and the team leader (TL) verified knowledge of how to seek advice from iwi and the Bay of Plenty District Health Board (BOPDHB) if required. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident’s personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A recent resident/family/whānau satisfaction survey includes evaluation of how well residents’ cultural needs are met, and this supported that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe.  The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. It is completed at commencement of employment. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence based policies, regular updates of the organisation’s policies based on best practice guidelines, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, physiotherapist, occupational therapy, wound care specialist, community dieticians, speech language therapists, services for older people, and education of staff. The GP confirmed the service sought appropriate medical intervention when required and were responsive to medical requests.  Staff reported they receive management support for external education and access to on line learning web sites to support contemporary good practice.  Other examples of good practice observed during the audit included a commitment to ongoing improvement in the care provided by the provision of regular physiotherapy services available to residents, the enabling of younger residents to develop the skills to return to living in the community, and the commitment of clinical staff to provide continuity and quality care during changes in management at Ultimate Care Oakland. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their own or their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Interpreter services can be accessed via Interpreting New Zealand when required. Staff knew how to do so and information on accessing the service was visible in all the entrances to the building. Staff reported interpreter services were rarely required due to all present residents being able to speak English. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | There is an organisation-wide strategic plan which is reviewed annually and includes the purpose, values, scope, direction and goals of the Ultimate Care Group. The organisation is led by a chief executive with business experience and a senior management team who have relevant experience in the sector. There is a regional manager with operational oversight of the facility and a clinical operations team who provide additional support. A member of this team (the audit and compliance manager), was present for the audit. A sample of monthly reports sent to the regional manager and clinical operations team, showed adequate information to monitor performance is reported. (See also standard 1.2.3 Quality and risk management).  The service is managed by a facility manager who holds relevant qualifications and has been a manager with the group for three years. She is currently the interim manager at Ultimate Care Oakland until a permanent manager is appointed. Prior to working for the Ultimate Care Group this person has held other management positions in the health and disability sector and has had nursing roles in the aged care sector. Responsibilities and accountabilities are defined in a job description and an individual employment agreement. The facility manager confirmed her knowledge of the sector, regulatory and reporting requirements and the organisation’s systems during the audit. She maintains currency through attending training provided by Ultimate Care Group and maintaining her nursing practising certificate (sighted).  The service holds contracts with the Bay of Plenty District Health Board (BOPDHB) for aged related residential care, aged related hospital services, long term support for chronic health conditions and respite care, and with the Ministry of Health (MOH) for people under 65 and residential disability services for people with either intellectual and/or physical disabilities. On the first day of the audit there were 54 residents receiving services.  Under the providers contract with BOPDHB there were 22 residents receiving rest home care and 24 receiving hospital care. Under their long term support for chronic health conditions contract, one resident was receiving rest home care and two residents were receiving hospital level care. Under the providers contract with the Ministry of Health for people under age 65 there were two residents receiving rest home care and three residents receiving hospital level care. This contract now combines the provider’s contracts for residential disability services and for people under 65 who require rest home or hospital level care.  As noted that in September 2016 and January 2017, 20 beds in the facility are not currently in use and so Ultimate Care Oakland is operating at a capacity of 65 beds. There are seven beds certified for rest home level care and the remaining beds are all certified for dual use care. The co-located retirement village is in a separate, standalone apartment building known as Copper Beach Apartments. There are no services provided to these residents by the aged care facility. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | On the days of the audit the clinical services manager was new in her role, having started a month prior to the audit. When the facility manager is absent, the clinical services manager carries out the required duties under delegated authority. She will be assisted by the regional manager for the facility. There is also an experienced registered nurse team leader who has worked at Ultimate Care Oakland for 18 months who will also provide assistance.  During absences of key clinical staff, the clinical management is overseen by members of the national office clinical team, including the audit and compliance manager. This person is an experienced RN who has worked in the sector as a facility manager.  Staff reported that the current arrangements work well. |
| 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 organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes objectives which link to the organisation’s strategic plan, the management and monitoring of adverse events, compliments and complaints, internal audit activities, maintaining certification, regular resident satisfaction surveys, monitoring of outcomes, clinical incidents including infections and use of restraints and enablers with a focus on restraint minimisation.  A range of meetings are held each month including a staff meeting, registered nurses, health and safety, infection control, restraint, and continuous quality improvement (CQI). Some of these meetings are combined. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the CQI and staff meetings.  Staff reported their involvement in quality and risk management activities through attendance at staff meetings and combined CQI meetings (these meetings include health and safety, infection control, restraint and continuous quality improvement - CQI), as well as internal audit activities. If staff are unable to attend meetings, the minutes are available to read and signature pages record that this occurs. This was confirmed at interview and review of meeting minutes with attached signature pages. Relevant corrective actions are developed and implemented to address any shortfalls.  Resident and family satisfaction surveys are completed annually. The most recent survey showed that residents feel welcome – respondents rated this question the highest mark of three out of three. Other questions relating to being comfortable and settled at Ultimate Care Oakland were similarly rated at a high level.  Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. All documents seen during the audit were current.  The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The quality and risk management plan, which included the risk register, was current at the time of the audit. The audit and compliance manager described the process the organisation has been going through to develop and prepare the 2018 quality and risk management plan. This was available in the facility, although not yet required until the beginning of the next calendar year. A current hazard register was also sighted. |
| 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 facility manager described essential notification reporting requirements, including for pressure injuries. They advised there has been notification of one significant event made to the Ministry of Health, since the previous audit. Evidence of the section 31 notification was seen and confirmation obtained from national office that although appropriate external agencies were notified no further ongoing action was required.  Staff document adverse and near miss events on an accident/incident form. A sample of the adverse events forms and electronic database they are entered into was reviewed. This showed that these were fully completed, adverse events were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported through the electronic system which provides direct reporting through to Ultimate Care Group national office.  Reports provided by national office are sent to each facility on a monthly basis. From January each year onwards the data is cumulative. Sighted during the audit were graphs which included data from January 2017 – November 2017. (The December event data was not due to be submitted by the date of the audit.) Staff confirmed that this information is made available to them and reviewed at staff meetings. They stated that they understand the data and it is useful to them. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.  Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after three months in the role and then annually thereafter.  Continuing education is planned on an annual basis. It includes mandatory training and competency assessment requirements. Care staff have either completed or commenced a New Zealand Qualifications Authority education programme to meet the requirements of the provider’s agreement with the DHB and meets the needs of residents who are under 65 with disabilities. Training is delivered through online options, at meetings and staff handovers, and staff confirmed this during interviews. Detailed monitoring of training completion is maintained and was reviewed with the facility manager and audit and compliance manager.  There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and annual performance appraisals were up to date. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents, using a range of tools to do this. These include the interRAI acuity reports and occupancy.  An afterhours on-call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed during the audit supported this. The 2017 residents’ survey results and compliments received during 2017 also indicated satisfaction with care provided.  Observations and review of a three week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All registered nurses and activities staff members have first aid certificates. Sampling of personnel files determined that these were current. There is 24 hour/seven days a week RN coverage in the hospital. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident’s name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents’ information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents enter Ultimate Care Oakland when the need for service has been identified and their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM) or the clinical services manager (CSM). They are also provided with written information about the service and the admission process.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the BOPDHB ‘yellow envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including the interRAI transfer report, medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN and a caregiver against the prescription and are verified as having been checked on the electronic medication record. A system is in place that ensures the monthly checking and replacement of expired medications. The first date of use of eye drops is recorded on the box. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.  Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the electronic medicine chart.  There was one resident who self-administers medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.  Medication errors are reported to the RN, TL and CSM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.  Standing orders are not used. |
| 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 food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in March 2017. Recommendations made at that time have been implemented.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, is available.  Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | If a referral is received by Ultimate Care Oakland, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the team leader (TL). There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Resident information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of seven trained interRAI assessors on site. Another RN has just commenced the interRAI training. A review of a resident following a fall and a bang to the head, evidenced comprehensive assessment being undertaken. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information (eg, weight loss, increased agitation, increased breathlessness, infections and pain). The needs identified by the interRAI assessments are reflected in the care plans reviewed. The care plan of the client receiving residential disability services is person centred, makes reference to wellbeing, community and the partners participation and the clients specific physical and health needs that require assistance.  Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional’s notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. Assessment findings are reflected in the care plan. Interventions identified the diverse range of resident’s individualised needs in all areas of service provision (eg, pressure injury management evidenced past pressure injuries now healed and pressure injury prevention management in place to prevent recurrence). The GP interviewed, verified that the care provided to residents was good and had improved over the past few months. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents’ needs. |
| 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 | The activities programme is provided by a qualified diversional therapist (DT), an activities co-ordinator at present completing the DT training and a recreation co-ordinator. All are working between three and five days per week.  A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated regularly and as part of the formal six-monthly care plan review.  The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included exercise sessions, visiting entertainers, quiz sessions, numerous outings, men’s group, daily news updates and attendance at community events. The activities programme is discussed at the residents’ meetings and indicated residents’ input is sought and responded to.  Younger residents who reside at Ultimate Care Oakland, are enabled by the recreation personnel to participate in community activities of their choice(eg, attending the movies, local clubs, going fishing, shopping, playing pool downtown, and ‘cossie club’.) Younger residents each have an individualised programme, and one of the activities personnel co-ordinates attending to their daily routines.  Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents’ needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for infections, pain, and weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to older persons’ mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance (as evidenced during audit with a resident who had a fall), if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary.  An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.  There is provision and availability of personal protective clothing and equipment (PPE) and staff reported sufficient supplies being available at all times. When appropriate staff members were observed using PPE.  Two household staff were interviewed and they confirmed the availability of training, information and access to the external chemical and cleaning product supply company. Both demonstrated knowledge of appropriate waste management protocols. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness, which was issued on 21 March 2017, is publicly displayed.  Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe and independence was promoted.  External areas are safely maintained and are appropriate to the resident groups and setting. Internally there are handrails throughout the facility, safe transitions between different areas, and signage where needed to direct visitors. Residents were observed moving around the facility either independently, using mobility equipment and with assistance as their abilities allow.  The 2017 residents’ survey has just been collated by national office and the results returned to the facility. For the statement ‘the facility is in a good state of repair’ Ultimate Care Oakland has scored another three (see standard 1.2.3 Quality for rating levels). |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes toilets for visitors and staff. There is a combination of shared ensuite bathrooms and communal bathrooms for residents throughout the facility.  Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents’ independence and safety. Bathrooms and toilets have appropriate privacy indicators and locks. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.  There is room to store mobility aids and wheel chairs in residents’ rooms. Residents and staff reported the adequacy of bedrooms. Wheelchairs, hoists and mobility equipment can be stored in cupboards in each wing/area of the facility if they are not required continuously. This assists with promoting independence and mobility for all, as it ensures hallways and space is uncluttered. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for residents to engage in activities. Each wing/area has their own dining and lounge room, with sufficient space for all residents in that wing to eat together and use the lounge for recreation, watching television and other activities of their choice. These areas enable easy access for residents and staff. Residents can access other areas for privacy, if required.  The facility is accessible for residents with disabilities and those who are under 65. The needs of this group are provided for (as noted in standard 1.3.7) and there are a range of alternative private spaces available in additional to the communal areas.  Furniture is appropriate to the setting and residents’ needs. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry is undertaken on site in a dedicated laundry. A dedicated laundry staff member was interviewed and demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.  The 2017 residents survey had several questions relating to cleaning and laundry services. In response to the question ‘Is the facility clean?’ – respondents indicated a rating of three (as noted this is the highest score). In response to: ‘Is your room kept clean?’ The rating was also three. In response to the question: ‘Are your clothes returned from the laundry in a satisfactory condition?’ The rating was 2.6 out of three. And in response to the statement: ‘Laundry and cleaning staff are friendly and helpful?’. The rating was 2.7 out of three.  There is a designated cleaning team who have received appropriate training. These staff have completed appropriate training in the facility’s policies and procedures, the use of the chemicals and cleaning products and core topics required of staff working in the aged care sector. This was confirmed during an interview of a cleaning and a laundry staff member and review of personnel records.  Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme. The most recent internal audits of both services were completed within the last three months. Minor corrective actions were noted and addressed (eg, cobwebs around the top of a doorway into the library). Both issues were reported through the CQI meeting and followed up through to resolution. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on 3 November 2006. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent was in November 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. (See resident register below.)  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ’s were sighted and meet the requirements for the up to 65 residents. A 2000 Litre water storage tank is located at the complex. Emergency lighting is regularly tested.  Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly.  Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and monitored by night staff. There is a resident register for use in emergency which lists each person’s mobility needs and requirements during an evacuation. This is maintained to ensure that it accurately reflects the residents living in the facility at any time and their location. The current resident register was sighted during the audit and is up to date. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, with opening external windows and curtains which are in good condition.  Heating is provided by electric heating, heat pumps in the hallways and communal areas. Areas were well ventilated and cool throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. |
| Standard 3.1: Infection control management  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. | FA | The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the TL. The infection control programme and manual are reviewed annually.  The TL is the designated infection control nurse coordinator (ICC), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CSM, FM and the organisation’s national quality manager and tabled at the monthly staff, RN and quality/risk meetings. Infection control statistics are entered in the organisation’s electronic database and benchmarked within the organisation’s other facilities. The organisation’s national quality manager is informed of any IPC concern.  Signage at the main entrance to the facility during the winter months requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC has appropriate skills, knowledge and qualifications for the role, and is being assisted by the organisation’s external infection control advisor, the organisation’s clinical coach, and the BOPDHB infection control nurse. The ICC has undertaken on line training in infection prevention and control and will attend the BOPDHB infection control study day in the New Year, as verified in records sighted. Well-established local networks with the infection control team at the BOPDHB are available. The coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The ICC and CSM confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures  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. | FA | The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviews and audits verified knowledge and compliance of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the ICC. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in urinary tract infections.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather. |
| 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 | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident’s clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.  The ICC reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation’s electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group’s other aged care providers.  There have been no outbreaks of Norovirus in the past two years. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures and practice and her role and responsibilities.  On the day of audit, five residents were on the restraint register with approved restraints. There were no residents using enablers. The restraint coordinator understood the definitions of restraints and enablers and that enablers are used voluntarily at a resident’s request. A similar process is followed for the use of enablers as it is for restraints.  Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint approval group, made up of the restraint coordinator the RN team leader and clinical services manager, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents’ files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.  Evidence of family/whānau or EPOA involvement in the decision making was on file in each case.  Use of a restraint or an enabler is part of the plan of care. This was confirmed through review of four of the five residents who had approved restraints at the time of the audit. The fifth person was on a two week trial with the restraint being removed. This was recorded on the restraint register and had been approved by the restraint approval group and was being overseen by the restraint coordinator. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The restraint coordinator described the documented process. Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator’s involvement, and input from the resident’s family/whānau or EPOA.  The GP is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident’s safety and security. Completed assessments were sighted in the records of residents who were using restraints.  The restraint coordinator described how they are involved and the restraint process and how information is provided and explained. Files reviewed confirmed that family/whānau or the resident’s EPOA is involved in the assessment and decision making process. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats, low beds and engagement in activities).  When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.  A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.  Staff have received training in the organisation’s policy and procedures and in related topics, such as positively supporting people with challenging behaviours. This was provided by the organisation’s clinical coach, who also provided the restraint coordinator and RN team leader with some additional training in restraint minimisation. Both staff members were interviewed and understood that the use of restraint is to be minimised and how to guide other care staff in maintaining safety when restraints are in use. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Review of residents’ files, and the restraint register, showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, three monthly restraint evaluations and at the restraint approval group meetings. Files reviewed confirmed that families/whānau are involved in the evaluation process and that they are satisfied with the restraint process.  The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the GP, staff and families.  A six-monthly internal audit that is carried out also informs these meetings. The most recent audit was completed in October 2017. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the restraint coordinator confirmed that the use of restraint has been reduced from nine to five restraints in use over the past 12 months. Half of this reduction (two residents) is due to an active process of reducing the use of restraint by exploring alternatives. At the time of the audit, a third person was on a two-week trial of the restraint being discontinued, with appropriate monitoring and guidance notes in their care plan and restraint register. |

# 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.

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| 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.

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End of the report.