

The Ultimate Care Group Limited - Ultimate Care Ranburn

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	The Ultimate Care Group Limited
Premises audited:	Ultimate Care Ranburn
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 23 April 2018 End date: 24 April 2018
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:	60

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
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 Ranburn provides rest home and hospital level care for up to 71 residents. The service is operated by the Ultimate Care Group (UCG) and managed by a nurse/facility manager, with support from a regional manager and clinical support team and onsite support from a clinical service manager.

The most significant change to the service since the previous audit in 2016 has been the appointment of a new facility manager and clinical services manager. Residents and families spoke honestly and freely and were generally positive about the care provided.

This surveillance 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, a general practitioner and a telephone interview with an advocate from the local Nationwide Health and Disability Advocacy Service. Three members of the UCG management team were also interviewed by teleconference to discuss the findings identified at this audit.

This audit identified 12 areas requiring improvement. There is concern about ongoing staff shortages and continuity of care (which relates to staffing). The timeliness of interventions and updating of care plans, activities in the secure dementia unit, evaluation of care, medicines and adherence to restraint processes needs improvement. The two actions required from the previous 2016 certification audit have been implemented to good effect and are now closed.

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

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. 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 were 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.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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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 based on a range of clinical information. Short term care plans are developed to manage new problems that might arise. Residents and families interviewed reported being well informed and involved in care planning and that the care provided meets their needs.

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines management is implemented using an electronic system. Medications are administered by registered nurses and care staff, 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 and this is 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

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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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The organisation has implemented policies and procedures that support the minimisation of restraint. There was one enabler and two restraints in use at the time of audit.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken, 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	10	0	0	7	2	0
Criteria	0	31	0	1	8	3	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The facility manager is responsible for complaints and there are systems in place to manage the complaints processes. A complaints register is being maintained and contains sufficient detail for an audit trail about each complaint. The documents reviewed and telephone interview with an advocate from the Nationwide Health and Disability Advocacy Service (Northland Office) confirmed that complaints are managed in a timely, respectful and appropriate manner.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes. The complaints process was readily accessible and displayed. Quality and staff meeting minutes evidenced reporting of complaints to staff. Care staff confirmed this information is reported to them.</p> <p>There have been no known complaints received or investigated by the Office of the Health and Disability Commissioner (HDC). Northland District Health Board (NDHB) have investigated one complaint concerning the transfer of a resident. The investigation was partially substantiated, and the service has carried out the corrective actions required. The DHB confirms that this complaint is closed out. There have been no investigations by the Ministry of Health, the Accident Compensation Corporation (ACC), Police or Coroner since the previous audit.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to most residents being able to speak English and staff or family members being able to provide interpretation as and when needed.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The Ultimate Care Group Limited (UCG) is the governing body responsible for the services provided. There are established systems that define the scope, direction and goals of the organisation and all UCG facilities, as well as the monitoring and reporting processes against these systems.</p> <p>The service business plan and quality and risk management plans are reviewed annually. These outline quality objectives and indicators and the overall direction and goals of the service. Ultimate Care Ranburn has their vision statement, philosophy and core values on display. The service philosophy is presented in an understandable form and is available to residents and their family/representative or other services involved in referring clients to the service.</p> <p>The service is managed by a facility manager (FM) who does not hold a current practising certificate as a RN but has relevant qualifications and experience in the sector. This person has been in the role for less than two years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The FM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending external education and sector meetings, and regular meetings with his manager and peers within the organisation. The FM is supported by a clinical services manager (CSM) who is responsible for oversight of the clinical care of residents and has been in the role since April 2017. The CSM has a current practising certificate.</p> <p>The regional operations manager and the audit and compliance manager for UCG provide support to the facility manager and clinical services manager. These people and the general manger were also interviewed by teleconference during the audit.</p> <p>The FM provides monthly statistical reports to the regional manager. Reports include reporting on quality and risk management issues, occupancy, HR issues, quality improvements and internal audit outcomes. The CSM reports on incidents and accidents and clinical indicators.</p> <p>Ultimate Care Ranburn holds contracts with Northland DHB for aged residential hospital and rest home care, including dementia services, respite care, young people with disabilities under 65 years (YPD) and palliative care. On day one of this audit there were 60 residents on site. Twenty seven were hospital residents (including one under 65 years of age), 19 rest home residents and 13 residents requiring</p>

		dementia level care. Two of the rest home residents were on site for short stay (respite) care.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The quality and risk management plan guides the quality programme and includes goals and objectives. There was evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. Corrective action plans are being developed, implemented and reviewed. There is an internal audit programme and completed internal audits for 2017 to 2018 were reviewed. The collated resident and family satisfaction surveys for 2017 indicated that residents and families are satisfied or very satisfied with the services provided. Quality improvement data is being reported to UCG head office as well as to staff via various monthly meetings (for example, Health and Safety meetings, Quality and Infection control, full staff meetings and residents' meetings.)</p> <p>Various clinical indicators and quality and risk issues are discussed at these meetings and documented. Minutes of meetings along with clinical indicator reports, graphs and benchmarking data is available for staff. Resident meetings are held monthly, and residents confirmed that any issues they raise at their meetings are dealt with by management.</p> <p>The corrective action required from the 2016 audit about timeframes for the completion of corrective action is now resolved. This was confirmed by review of meeting minutes and corrective action plans.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and references legislative requirements. These are reviewed regularly and were current. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for the service delivery.</p> <p>Actual and potential risks are identified and documented in the hazard register. The hazard register identified hazards and showed the actions put in place to minimise, isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The health and safety coordinator is responsible for hazards and demonstrated good knowledge. Staff confirmed they understood and knew how to document and raise any identified hazards/risks.</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</p>	FA	<p>Adverse, unplanned or untoward events are documented on an incident/accident form which is uploaded to the UCG database and a hard copy placed in residents' files. Data included summaries and registers of various clinical indicators including falls, medication errors, unintentional weight loss, skin tears, and incidents of challenging behaviour.</p> <p>Documentation reviewed and interviews of staff evidenced appropriate management of adverse events.</p> <p>There is an open disclosure policy. Communication with families following adverse events involving the</p>

<p>appropriate their family/whānau of choice in an open manner.</p>		<p>resident, or any change in the resident's condition was documented on the forms. There has been a complaint from family who were not advised about the transfer of their relative to Whangarei Hospital. Investigation revealed where the gap occurred, and new processes are in place to minimise recurrence.</p> <p>The FM and CSM are aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Policy and procedures comply with essential notification reporting (eg, health and safety, human resources, infection control). There have been three section 31 notifications of pressure injuries to the Ministry of Health, and one staff injury to WorkSafe NZ since the last audit.</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>	<p>FA</p>	<p>Staff 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.</p> <p>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 a three-months.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. Three registered nurses and the CSM are maintaining the annual competency requirements to undertake interRAI assessments.</p> <p>Six personnel records reviewed demonstrated completion of ongoing training and completion of annual performance appraisals.</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>PA High</p>	<p>UCG state that their documented and implemented process for determining staffing levels and skill mixes is based on the Indicators for Safe Aged-care and Dementia-care for Consumers SNZ HB 8163:20015.</p> <p>The planned rosters are often thwarted by unexpected staff absences. This was reflected in the difference between the planned roster and the number of staff on site.</p> <p>The FM stated that UCG allows for enough RN hours but that there were currently not enough RNs available. There was one RN working a 12 hour shift to cover the shortfalls. Employee records show</p>

		<p>nine RNs are currently employed but two were unavailable/on leave at the time of this audit. The CSM was also on leave (but did attend for the afternoon of day one) and another FTE RN was acting up in the role of CSM. There have been eight resignations of RNs in the past six months. The FM has been actively recruiting for replacement RNs and caregivers with the necessary skills and experience but many applicants encountered employment issues with immigration. UCG are also offering attractive employment packages.</p> <p>Interviews with UCG management on day two of the audit resulted in a commitment to send an extra RN/clinical support on site within a week. The service makes every attempt to adjust staffing levels to meet the changing needs of residents. On the days of audit, a bureau caregiver was working in the secure unit. There is a requirement in criteria 1.3.7.1 to provide planned activities in the dementia unit. There are requirements in 1.3.3 related to the timeliness and coordination of care.</p> <p>The CSM and FM are available on call and staff reported that reliable access to advice is available when needed.</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>PA Moderate</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>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.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. Documentation, interviews and observation evidence medications are not checked by an RN against the prescription, when the new supplies arrive. All medications sighted were within current use-by dates. Clinical pharmacist input is provided on request.</p> <p>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, however there was no evidence of weekly checks being undertaken in the past two weeks.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>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 are met. The required three-monthly GP review is completed, however not consistently recorded on the</p>

		<p>electronic medicine chart.</p> <p>There was one resident who self-administers medication at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner, however since October 2017 there is no evidence this has been reviewed three monthly as per policy.</p> <p>Medication errors are reported to the RN 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.</p> <p>Standing orders are not used.</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 food service is provided on site 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 within the last two years. Recommendations made at that time have been implemented. The food control plan is part of the organisation's member's group template and has approval to not require registration until 31 May 2018.</p> <p>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 is a qualified chef and has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>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.</p> <p>Evidence of the services response to any resident's dissatisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. A residents' food forum operates at Ultimate Care Ranburn and meets quarterly.</p> <p>Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are two staff on duty in each of the three dining rooms at meal times (refer 1.2.8.1) to ensure appropriate assistance is available to residents as needed. An interview with a family member, made mention of the need to be there at meal times, or otherwise the person notes that residents who need assistance often do not get their meals. Observation at audit noted minimal assistance being offered to a resident who had not eaten their meal. No action was taken when this was mentioned, as it was not deemed necessary.</p>

		Residents in the secure unit have their own kitchen and fridge in the unit. Interviews, observations and weight records verified the availability of food to residents always.
<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>	FA	<p>With the exception of that reported in criterion 1.3.3.4 and 1.3.8, observations and interviews verified the provision of care provided to residents was consistent with the documented plan of care (refer criterion 1.3.3.4). Residents and family interviews verified satisfaction with the care provided. Interventions around residents' generalised care needs, wound care and infection management was documented. The attention to meeting a range of resident's needs was evident in areas of service provision. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	PA Moderate	<p>The activities programme is provided by one trained diversional therapist.</p> <p>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.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. A twenty-four-hour activities plan is documented in the files of residents in the secure unit. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include exercises, visiting entertainers, quiz sessions an art group, pet therapy, church services and daily news updates. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. 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.</p> <p>It was observed however, that there were minimal activities occurring in the secure unit. Interviews with staff verify residents go out for drives, walks and attend events with rest home and hospital residents if they are able. Those that are not able have very little going on for them in the unit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery</p>	PA Moderate	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN, as was evident in the recent acute admission of two residents to the DHB.</p>

<p>plans are evaluated in a comprehensive and timely manner.</p>		<p>Formal care plan evaluations however, are not consistently occurring every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations when documented by the RN, are at times inconsistent with assessment findings, observations and progress notes. On a day to day basis where progress is different from expected, the service responds with clinical actions, but does not respond by initiating changes to the documented plan of care. Short term care plans were reviewed for infections and wound care plans for effectiveness in management.</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>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 01 August 2018) is publicly displayed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>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.</p> <p>The infection control nurse who is the CSM 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.</p> <p>A Norovirus outbreak in August 2017, identified that the facility should have responded earlier to the outbreak. This has been documented and processes included in the outbreak management plan.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Moderate</p>	<p>Ultimate Care Ranburn demonstrated that the use of restraint is actively minimised. The restraint coordinator who is a registered nurse was unavailable. The CSM who came in from annual leave to be interviewed, was not aware of the third restraint.</p> <p>Consent for the enabler was signed by the EPOA and interview with the resident confirmed they can ask for this to be removed. The assessments for the lap belt and the enabler bed rails failed to identify any</p>

		risks associated with the use of these. The policies and procedures have clear definitions of restraints and enablers, but staff do not appear to have a full understanding or knowledge about restraints.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p>	<p>PA Moderate</p>	<p>Policy and procedures clearly define the processes for approval and consent. An improvement is required to ensure all restraint are approved and consented for before implementation.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>PA Moderate</p>	<p>The restraint and enabler assessments did not consider or record the risks associated with the interventions planned. There was no assessment for the bed rail. Improvements are required.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>PA Moderate</p>	<p>The monitoring records for the bedrails of both the enabler and the unlisted bedrail were reviewed and found to be detailed in recording times off and on and the care provided while the rails were up.</p> <p>The previous improvement required in criterion 2.2.3.4 is resolved.</p> <p>An improvement is required in 2.2.3.5 because not all restraints were listed in the restraint register.</p>

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA High	<p>Actual rosters, (versus planned rosters) staff interviews and observations on the days of audit revealed problems with the provision of a stable workforce, who have the skills and experience necessary to meet the needs of high dependency residents, many of whom are clinically unstable and/or have disruptive behaviour.</p> <p>At the time of audit, one RN on the floor was rostered for a 12-hour shift (7am to 7pm and another RN 7pm to 7am) and caregivers were working additional hours and extra shifts. A bureau caregiver was working in the secure unit to cover for an unexpected staff absence. During the day an acting CSM was available to oversee</p>	<p>Interviews with staff, family and the GP, observations and comparison with the planned and actual roster revealed staff shortages on the day of audit. This was also reflected in the</p>	<p>Provide evidence that there are enough suitably qualified and experienced staff available for all shifts to meet the needs of high dependency residents</p>

		<p>and support with the care of 27 hospital, 19 rest home and 13 dementia care residents.</p> <p>Five caregivers and three nursing staff consistently described a lack of adequate staff available to manage workloads. The GP expressed concerns about staffing levels which they believe resulted in the prescribed treatments not always being carried out.</p> <p>One family member said they come in for four hours every day to support their relative taking in sufficient food and fluid to prevent recurrence of dehydration which occurred recently.</p>	<p>requirements under standards 1.3.3 and 1.3.7.</p> <p>There were not enough staff available to provide back up in the event of unplanned staff absences.</p>	<p>and the requirements for timeliness and coordination of care under standard three.</p> <p>Strengthen the system for back filling absent staff.</p> <p>30 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Interviews, documentation and observation verified a medication management system is in place to manage the safe and appropriate prescribing, dispensing and administration of medicines is occurring. However, the required weekly controlled drug check by two RNs has not occurred over the past two weeks. The facility has no documentation or a system in place that requires checking of medications when supplied by the pharmacy against the medication chart for accuracy in dispensing. Checking is observed to be occurring when being administered, by care staff and RNs. Six of thirty-two medication charts reviewed, had no verification the medication chart had been reviewed by the GP in the past three months, despite evidence verifying the GP had visited the resident.</p>	<p>A weekly check of the controlled drugs has not occurred over the past two weeks. Reconciliation of new medication supplies each fortnight by the RN is not occurring. The medication charts of all residents reviewed has not consistently occurred every three months</p>	<p>Provide evidence that controlled drugs are checked weekly for accuracy and new medication supplies are reconciled by the RN.</p> <p>30 days</p>

			by the GP.	
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	<p>A resident who self-administers medication was assessed in October 2017 as being competent to do so. The provider's policy of requiring three monthly reviews of competence has not been met. The resident, when interviewed, is aware of the responsibility and obligations in self-administering medication.</p>	<p>One resident who self-administers their medication has not had their competency reviewed.</p>	<p>Provide evidence that residents who self-administer medication are reviewed regularly to ensure they are competent to do so.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA High	<p>An initial assessment is undertaken and an initial care plan is completed within 24 hours of admission by a Registered nurse. The resident is reviewed by the GP within forty- eight hours of admission and monthly or three monthly if the resident is deemed medically stable.</p> <p>One of the fifteen files reviewed had no long-term care plan in place within three weeks of admission. Two of sixteen files had no weight recorded on admission. Seven of eleven files reviewed had not had the documentation in their care plans reviewed within the last six months. Seven of eleven files had no six-monthly evaluations recorded. One file of a resident with bedrails for restraint has no documented evidence of assessment (refer criterion 2.2.1.1)</p> <p>A teleconference with the auditors and three of</p>	<p>Provide evidence that long term care plans are implemented within three weeks of admission, weights are recorded on admission, care plans are evaluated and reviewed six monthly or earlier as residents needs change and</p>	<p>Provide evidence that each stage of service provision is provided within the required timeframes to safely meet the needs of the resident.</p> <p>60 days</p>

		the UCG management team on the day of audit, gave the auditors an assurance immediate clinical support will be provided to Ultimate Care Ranburn to ensure the level of risk is addressed immediately.	residents requiring restraint have documented assessments in place.	
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	PA High	<p>Systems are in place to promote continuity of care, such as progress notes, a verbal handover at the start of each shift, and written handover sheets.</p> <p>Twelve of sixteen care plans reviewed did not fully describe the care required to ensure continuity of care for these residents. A resident is described as a low falls risk, when a letter from the GP states they have had a history of falls at home. There is no documented falls management plan in the resident's notes. After numerous falls while admitted, one resulting in a fracture, the care plan still has no falls management plan, no evaluations, and the risk is still documented as low. Interviews verify the staff are aware the resident is at risk of falls.</p> <p>Four of four residents in the secure unit had no behaviour management plans in place to manage episodes of challenging behaviour. Interviews with staff and the RN verify staff are unaware of the individualised strategies to be implemented for each resident's episodes of challenging behaviour.</p> <p>Twelve of sixteen files reviewed had no updates in the care plans, or short-term care plans in place to manage one-off incidents or changes in the resident's required care (eg, catheter management, nutritional deficits, falls, medication</p>	<p>The service is not co-ordinated in a manner that ensures continuity of care is provided. Care plans do not accurately reflect the care the resident requires as per changes in needs. Staff are not familiar with all aspects of the residents' required care.</p>	<p>Provide evidence that the residents are receiving care that is co-ordinated and ensures continuity.</p> <p>60 days</p>

		<p>changes, instructions from DHB post admission). Interviews and observation evidence staff lack of knowledge in relation to specific care needs.</p> <p>A resident requiring restraint has no documentation in their care plan (refer criterion 2.1.1.4)</p>		
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Moderate</p>	<p>Observation and interviews verified there are minimal activities offered in the secure dementia unit (refer criterion 1.2.8.1). The diversional therapist responsible for activities is required to provide activities in all three areas of the facility and attend to a diverse range of residents' needs. Interview with the diversional therapist identifies magazines, puzzles and other activities are put out for residents in the unit, however very little time is spent in the unit due to demand from other more able residents in other areas of the facility. .</p>	<p>There are insufficient activities occurring in the secure unit.</p>	<p>Provide evidence that some regular activities programme specific for the secure unit is in place.</p> <p>90 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Moderate</p>	<p>Wound care plans were evaluated after each dressing change, as were short term care plans for infections.</p> <p>Four of four residents exhibiting challenging behaviour had no behaviour management plans, and therefore no interventions concerning behaviour to evaluate. One of these resident's care plan was evaluated by the RN, recording 'no change' despite numerous challenging behaviour events being documented.</p> <p>Care plans were not accurately reflective of the desired outcome and the care required (refer also criterion 1.3.3 and 1.3.4).</p> <p>A resident who self-administers medication had</p>	<p>Evaluations are rarely documented or indicate progress towards meeting the desired outcomes.</p>	<p>Provide evidence evaluations are documented and indicate achievement towards the desired goal.</p> <p>30 days</p>

		<p>no updated evaluation of competency (refer criterion 1.3.12.5).</p> <p>A resident requiring catheter care and a resident on anticoagulant therapy both had no plan for management and subsequently no documentation to evaluate the effectiveness of the plan.</p>		
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA</p> <p>Moderate</p>	<p>Wound care plans and short-term care plans regarding residents with infections, are evaluated and changes made when progress is different from expected. Expert advice is sought when residents' progress is different from expected, as evident by residents' recent referrals for specialist input from the DHB.</p> <p>Twelve of sixteen care plans reviewed, verify the documentation in the care plan is not updated to evidence changes are made when progress is different from expected (refer criterion 1.3.3.4 and 1.3.8.2).</p> <p>A resident who fell while being transferred in a hoist, had no update in the care plan to identify the specific actions required to be taken to prevent recurrence. Interviews with staff, verify they are unaware of any specific changes required when transferring this resident.</p>	<p>When progress is different to that expected the service does not respond by initiating changes to the service delivery plan.</p>	<p>Provide evidence that when progress is different to that expected the service responds.</p> <p>60 days</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	<p>PA</p> <p>Moderate</p>	<p>The resident with approval for PRN lap belt use, was not observed to be using a lap belt, but was left in a chair all day. Staff interviewed confirmed this person could not weight bear and needed a two person assist to stand. The resident was observed to not have a position shift or be moved from the chair for eight hours on day one and four</p>	<p>The resident with approved PRN lap belt has not been reviewed nor reassessed for periods of</p>	<p>Ensure all restraint interventions comply with policy and these</p>

		<p>hours on day two.</p> <p>The enabler assessment states three monthly review but there has been no review since it was started on 9 January 2018.</p> <p>Restraint assessments do not identify the risks associated with the type of restraint in use.</p>	<p>sitting in an armchair which the person cannot get out of without assistance.</p> <p>Reviews of restraint are not occurring three monthly, as directed.</p>	<p>standards.</p> <p>90 days</p>
<p>Criterion 2.2.1.1</p> <p>The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.</p>	<p>PA Moderate</p>	<p>One hospital care resident has had bedrails being used and monitored since January 2018, but there is no documented assessment, consent or reference to these in the care records. This restraint was not listed in the register and the CSM was not aware of this restraint.</p>	<p>There was no documented evidence of assessment, consent or review of the hospital resident with bedrails in place.</p>	<p>Ensure all restraint interventions comply with policy and these standards.</p> <p>90 days</p>
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the</p>	<p>PA Moderate</p>	<p>Review of three residents records revealed that one resident who had bedrails in place had not been assessed and the other two (enabler and lap belt) had not been assessed for the risks associated with their use. There is a definite risk of skin breakdown for the resident with approval for PRN lap belt due to long periods of inactivity and no position change. (Investigations revealed that there is no redness or break down of skin) Although the lap belt is not being used, the resident is seated in an armchair all day and cannot get up from the chair without two people</p>	<p>There were no risks related to the use of the enabler or restraints in use.</p> <p>The resident in the armchair requires reassessing for risks</p>	<p>Ensure all restraint interventions comply with policy and these standards.</p> <p>60 days</p>

<p>past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the consumer being held against their will; (f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies.</p>		<p>to assist them.</p>	<p>associated with sitting for long periods.</p>	
<p>Criterion 2.2.3.5 A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.</p>	<p>PA Moderate</p>	<p>The restraint register listed one resident with PRN (as required) restraint a (lap belt) and one resident using an enabler (bed rail when in bed) but did not list another resident with bed rails in place.</p>	<p>The restraint register is not current as it does not include all residents on restraint.</p>	<p>Ensure all restraint interventions comply with policy and these standards. 30 days</p>

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

No data to display

End of the report.