

# The Ultimate Care Group Limited - Bishop Selwyn Lifecare

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	The Ultimate Care Group Limited
<b>Premises audited:</b>	Ultimate Care Bishop Selwyn
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 20 September 2018    End date: 20 September 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	67

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	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 Bishop Selwyn provides rest home and hospital level care for up to 79 residents. The service is operated by Ultimate Care Group Ltd and managed by a facility manager and a clinical services manager. Residents and families spoke positively 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, management, staff, and a general practitioner.

There were no areas requiring improvement as a result of this audit.

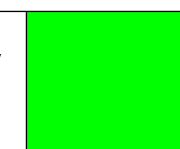
## Consumer rights

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. Staff provide residents and families with the information they need to make informed choices and give consent.

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.
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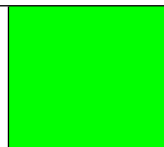
Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective.

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. Staffing levels and skill mix meet the changing needs of residents.

## Continuum of service delivery

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



Standards applicable to this service fully attained.

The registered nurses develop, review, update and evaluate residents' care plans at least once every six months, or sooner if the patient's needs change. Residents and their family/whānau have input into the development and review of their care plans. Residents and their family/whānau interviewed reported they were very satisfied with the care provided by staff.

There is an activities programme suitable for the needs of those living at Ultimate Care Bishop Selwyn and residents are free to choose which activities they wish to participate in. One-to-one and group activities are provided by the three activities staff. Residents' meetings minutes reviewed showed residents enjoyed the variety of activities and had opportunity to provide input into future planning.

A safe and appropriate electronic medication system is in place. The staff interviewed were aware of their responsibilities and had current medication competencies. Weekly and six-monthly stock checks of controlled drugs occurs with accurate records and appropriate storage.

Food, fluids and nutritional needs of the residents are provided in line with nutritional guidelines for the older person. Special diets and requirements were being met. A nutritional profile is completed on admission and given to the kitchen staff with evidence of six-monthly reviews. Residents and family/whānau interviewed felt the menu was varied and meals provided were of a good standard.

## 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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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.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Three enablers were in use at the time of audit. There were no restraints in use.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The type of surveillance is appropriate for the size and type of facility. Review of documentation evidenced that the reporting of infections followed policies and procedures that support the infection prevention and control programme. Results of surveillance are collated and shared at quality meetings and this information is reported back to staff at shift handover and staff meetings for actioning. Information is displayed for staff to observe in the staff room and is also compared with other Ultimate Care Group facilities.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	16	0	0	0	0	0
<b>Criteria</b>	0	39	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints 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 do so.</p> <p>The complaints register reviewed showed that four complaints have been received over the past year and that actions taken, through to an agreed resolution, were documented and completed within the timeframes. 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. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their 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. Staff understood the principles of open disclosure, which was 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 all residents able to speak English.</p>



environment conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Ultimate Care Bishop Selwyn's strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer-term objectives and the associated operational plans. A sample of monthly reports to the board of directors showed adequate information to monitor performance is reported including occupancy, staffing, financial performance, emerging risks and issues and complaints.</p> <p>The service is managed by a transition facility manager (the regional manager) who holds relevant qualifications and has been in the role for several years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The regional/facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through organisational seminars and sector meetings.</p> <p>The service holds contracts with the district health board (DHB) for respite, rest home, complex medical conditions, hospital and palliative care and the Ministry of Health (MoH) for younger persons with a disability (YPD). Thirty-nine residents were receiving services under the rest home contract, twenty-eight under hospital care. There were no residents under YPD or palliative care at the time of audit. Six residents were in 'Occupational Right Agreement' apartments. Apartments are within the facility's hospital environment and included in hospital staffing numbers.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes, and clinical incidents including infections and adverse events.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team, quality and risk and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, and feedback from management. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed a lack of outings in the van and return of correct clothing from laundry as issues. The service has increased the number of van outings and sent reminders about naming clothing. Both areas have showed an improvement as confirmed in meeting minutes sighted.</p> <p>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.</p> <p>The regional/facility manager described the processes for the identification, monitoring, review and reporting of risks</p>

		and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated and reported to head office. This is transferred to an electronic risk reporting system for analysis.</p> <p>The regional/facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been two notifications of significant events relating to security breaches (since reassessed for dementia care) made to the Ministry of Health, since the previous 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>	FA	<p>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.</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-month and annual period.</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. 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.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There 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 according to the interRAI acuity data reports. 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 supported this. Observations and review of four weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage in the hospital.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>An electronic system is used to provide safe medication management that complies with current legislative requirements and safe practice guidelines. The staff were aware of their roles according to their scope of practice, they have undergone training and have current competencies.</p> <p>Medicines arrive from the pharmacy in blister packs. The packs are checked against the medication chart by the clinical services manager and team leader and entered into the system. Controlled drugs are stored securely in accordance with requirements and checked by two staff (one who is a registered nurse, the other a medicines competent staff member) for accuracy. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The medication fridge was maintained at a temperature within the recommended range. Stock was within current use by dates. All non-packaged items were stored in an orderly manner in a locked cupboard.</p> <p>The GP is reviewing medications three monthly or sooner if required. Commencement and discontinuation of medications and reason for pro re nata (PRN) medications were documented and meet requirements.</p> <p>There have been no medication errors but there is a system in place if required for analysis of these.</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</p>	<p>FA</p>	<p>The food service is provided on site by a cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows winter and summer patterns and rotates over a four week cycle. It has been signed off by a qualified dietitian and recommendations made have been implemented. Those with dietary restrictions and modified textures are having their needs met. Residents interviewed, and resident meeting notes reviewed confirmed that the meals were satisfactory, with drinks and snacks available between meals.</p> <p>Residents' files reviewed demonstrated monthly weighs were undertaken and nutritional needs were being met. On admission, a nutritional file is developed detailing likes, dislikes, allergies, special cutlery required and any modified texture needed. A copy of this is held in a folder in the kitchen and reviewed and updated six monthly or earlier if</p>

<p>service is a component of service delivery.</p>		<p>needs change. Residents are referred to the dietitian for input if they experience unexplained weight loss.</p> <p>Visual inspection of the kitchen and food storage areas showed clean work areas, an orderly pantry and evidence of stock rotation. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Fridges, freezers and food temperatures were within the recommended range. All kitchen staff have completed relevant food handling training.</p> <p>A meal time observed showed a calm atmosphere with no hurry for the residents to eat their meals and adequate room for staff to move around tables. Those requiring assistance were helped in a respectful and dignified manner.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation and interviews with residents and family/whānau revealed they were involved in the formulation of long-term care plans which were consistent with residents' needs, goals and plan of care. The GP stated that medical input is sought in a timely manner with full and detailed information handed over and medical orders followed. Appropriate equipment and resources (eg, hoists, pressure relieving devices and mobility aids) were available and suited to the levels of care provided. Staff were trained in the use of equipment and had gained competency as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Ultimate Care Bishop Selwyn has three activities staff; one trained diversional therapist (DT), one DT in training and one due to start. They cover both service streams over the week, leaving movies, games or puzzles out for the weekend when staff or residents initiate activities. The facility has two vans that are used for outings and shopping trips. The activities staff receive feedback from residents' meetings and suggestions of things to try, and Ultimate Care Group (UCG) head office also send a list of activities to include. The programme is varied and includes singing, church services, visits to and from a local preschool, games, puzzles and entertainers. On admission, a social history including cultural details, is obtained and from this goals are set with evaluations occurring six monthly, in line with interRAI assessments. Residents and family/whānau interviewed shared that the programme is interesting and meets their needs. Residents are free to choose which activities to participate in, with one-to-one 'chats' offered to those who opt to remain in their rooms.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	<p>FA</p>	<p>Residents' care is reviewed on each shift and any changes reported to the registered nurse and documented in the residents' progress. During hand over between shifts anything that needs follow up is passed on to the oncoming shift staff.</p> <p>Formal care plan evaluations occur every six months in line with the interRAI reassessment, or sooner if a resident's</p>

<p>evaluated in a comprehensive and timely manner.</p>		<p>needs change (eg, time spent in the hospital). Short term care plans are used for wounds or infections. Documentation showed that short term care plans were reviewed and progress evaluated as clinically indicated. There was evidence of unresolved problems being transferred to the long-term care plan when required. Residents and family/whānau confirmed that they were involved in the process of evaluation and kept informed of any changes as observed on the family contact page.</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 July 2019) 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 and includes infections of the urinary tract, upper and lower respiratory tract, skin, wounds, gastrointestinal tract, eye, ear, nose, and throat, and multi resistant organisms. Data is gathered each month and the clinical nurse manager graphs them observing for trends and possible causes, reported at quality meetings and then to the governing body. This information is available to staff at handover, staff meetings and is displayed in the staff room. It is also compared against other UCG facilities with monthly comparisons as well as yearly comparisons of the same months.</p> <p>There have been no infection outbreaks since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>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.</p> <p>On the day of audit, no residents were using restraints. Three residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p>

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## Specific results for criterion where corrective actions are required

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

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

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

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.