

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: 11 February 2019	End date: 12 February 2019
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:	66	

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, hospital and dementia care for up to 77 residents. Ultimate Care Ranburn is owned by Ultimate Care Group Ltd. The facility is managed by a facility manager and clinical services manager. Residents and families spoke positively about the care provided.

This unannounced 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.

The 12 findings from the previous audit were reviewed. Improvements have been made to staffing, medication and restraint. Six areas have yet to be fully addressed and four new areas requiring improvement have been identified. These relate to reporting of quality data to staff, performance appraisals, competencies for restraint and controlled drug management, food safety training, consent, admission requirements, care planning, evaluations, activities, medication and GP reviews.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to interpreter services if required.

The facility manager is responsible for the management of complaints and a complaints register is maintained. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The Ultimate Care Group Limited is the governing body and is responsible for the service provided. A strategic business plan and quality and risk management systems are fully implemented at Ultimate Care Ranburn. Systems are in place for monitoring the service, including regular reporting by the facility manager and clinical services manager to the national support office.

The facility is managed by a facility manager who is new to the position. The facility manager has experience in the aged care sector and is supported by a clinical services manager who is also new to the position and is responsible for the clinical service.

There is an internal audit programme. Adverse events are documented on incident/accident forms. Corrective action plans are developed, implemented, monitored and signed off as being completed to address any areas that require improvement. Quality, health and safety, registered nurses, staff and residents' meetings are held on a regular basis. Actual and potential risks including health and safety risks are identified and mitigated.

Human resources processes are followed. An in-service education programme is provided.

The documented rationale for determining staffing levels and skill mixes is based on an electronic rostering tool that calculates staffing requirements based on the needs of residents. Registered nurses are rostered on duty at all times. The facility manager and clinical services manager are rostered on call after hours.

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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The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. There are policies in place to support assessment, planning, provision of care, evaluation and exits for residents to safely meet the needs of the residents and contractual requirements. All residents entered into the interRAI database have an up to date interRAI assessment.

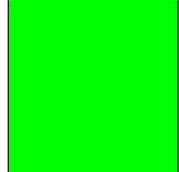
When there are changes to the resident's needs a short-term plan is developed and evaluated.

The service provides planned activities with the support of an activities team and volunteers.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a four-week rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met.

A medication policy is in place to guide registered staff. A safe medicine administration system was observed at the time of audit.

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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A building warrant of fitness is displayed. There have been no structural alterations since the previous audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

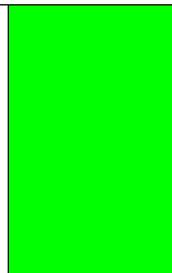


Standards applicable to this service fully attained.

The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There was one resident using a restraint at the time of audit. No residents were using enablers.

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.

Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection.

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	13	0	2	4	1	0
Criteria	0	33	0	3	6	1	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 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	<p>PA Moderate</p>	<p>Nursing and care staff interviewed understood 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 but not all resuscitation consent forms were signed for appropriately. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined. Documents in residents' files were sighted showing residents' incapacity to make decisions and enduring power of attorney had been enacted for residents unable to make an informed consent. Staff were observed to gain consent for day to day care.</p>
<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 complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The information is provided to residents and families on admission and there is complaints information and forms available throughout the facility. All complaints have been entered into the complaints register. Two complaints were reviewed and actions taken were documented and completed within the timeframes specified in the Code. Action plans</p>

		<p>reviewed showed any required follow up and improvements have been made where possible.</p> <p>The facility manager (FM) is responsible for complaint management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>The FM reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous surveillance 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>	FA	<p>Residents and families stated they are kept well informed about any changes to their own or their relative's status and 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 the local DHB if required.</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>	FA	<p>The business and strategic plans are reviewed annually and include the purpose, values, scope, direction, goals and objectives of the organisation. An organisational flowchart shows the positions within the organisation. Monthly reports are generated electronically and sent to the national support office. Reports include but are not limited to financial performance, occupancy, staffing, training, complaints, audits and any risks.</p> <p>The facility manager (FM) has been in the position since October 2018. The FM has experience working in the aged care sector and prior to this role was the FM at another aged care facility. The FM is supported by the clinical services manager (CSM) who has been in their position since October 2018. The CSM is an experienced clinical manager/RN and prior to this role was a clinical manager at another aged care facility. The CSM is responsible for oversight of the clinical service in the facility. The FM reported the regional operations manager visits at least fortnightly and also provides support via phone calls three to four times a week.</p> <p>Ultimate Care Ranburn is certified to provide accommodation for 77 residents with 66 beds occupied on the first day of audit. There were twenty-two</p>

		<p>hospital level residents including one resident funded by ACC, 25 rest home level residents including one resident ACC funded for respite care (two residents without a NASC assessment were situated in the rest home area, (link to 1.3.3.1) and 17 dementia care level residents. Six rooms have been approved as dual-purpose beds (rooms 39, 45, 51, 56, 57, 58).</p> <p>Ultimate Care Ranburn has contracts with the DHB for aged related residential care services, long term chronic health conditions, residential-non-aged care and respite care. A Ministry of Health contract is also held for carer support.</p> <p>The FM advised HealthCERT has been notified of the change of FM and CSM since the previous surveillance audit.</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>	<p>PA Low</p>	<p>The organisation has a comprehensive quality and risk management system that guides the quality programme and includes principles and quality targets.</p> <p>Quality data is being collected, collated and comprehensively analysed to identify trends. Corrective actions are developed and implemented with monitoring to make sure corrective actions have been effective. Apart from the staff meeting minutes, there was evidence of regular reporting and review of data including any trends. Although monthly reports, including graphs, are provided by the national support office, these are not provided to staff. The CSM demonstrated sound knowledge relating to quality and risk management. The RNs confirmed they are kept fully informed and discuss quality data at their meetings including trends and what corrective actions have been put in place.</p> <p>Resident and family satisfaction surveys are completed yearly. The 2018 survey showed residents and families are satisfied or very satisfied with the service provided.</p> <p>Policies and procedures are fully embedded at Ultimate Care Ranburn. They are relevant to the scope and complexity of the service, reflected current accepted good practice and referenced legislative requirements and refer to interRAI assessment process. Policies and procedures have been reviewed by the clinical advisory panel (CAP) and were current. New / reviewed policies are available for staff to read in the staff room and they are required to sign off these once read. Staff interviewed confirmed this. Staff also confirmed the policies and procedures provide appropriate guidance for</p>

		<p>service delivery.</p> <p>Actual and potential risks are identified and documented. The risk register includes but is not limited to clinical, environment, staffing and financial risks. A risk matrix is used to rate the level of risk. There are two health and safety representatives who are responsible for the management of hazards, including putting in place appropriate controls to eliminate or minimise all hazards on site. Hazards are communicated to staff and residents as appropriate. One of the health and safety representatives interviewed demonstrated a sound understanding of health and safety requirements. Staff confirmed they understood and implemented documented hazard identification processes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Adverse, unplanned or untoward events are documented by the CSM and RNs into the electronic system and are reviewed by the RN on duty and the CSM. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. Adverse event data is collected and reported to the national support office where it is analysed and benchmarked with the other facilities within the organisation. A report is generated and provided to the facility and the CSM is responsible for interpreting the data and reporting back to staff. Review of the graphs evidenced an increase in incident/accidents in the last three months. The FM reported this is the result of staff being encouraged to report all incident/accidents and near misses. Staff confirmed this and stated they feel supported to report and that the FM and CSM have encouraged them in a positive way.</p> <p>Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Staff are aware of essential notification responsibilities. The FM stated there has been one Section 31 notified for a pressure injury made to HealthCERT since the last surveillance audit. The FM reported there have been no other notifications made to external agencies apart from a change in managers.</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</p>	PA Moderate	<p>Policies and procedures relating to human resources management are based on relevant legislation and good employment practice. Staff files reviewed included job descriptions which outline accountabilities, responsibilities and authority, employment agreements, references, completed orientation and</p>

<p>requirements of legislation.</p>		<p>police vetting.</p> <p>New staff are required to complete the orientation programme prior to their commencement of care to residents, including specific components depending on the position description. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Staff reported the orientation process prepared them well for their role.</p> <p>The education programme is the responsibility of the FM. Documentation evidenced in-service education is provided at least monthly and during handover. External educators are sourced, and staff have the opportunity to attend sessions externally and are expected to share the information with the rest of the staff. Attendance is entered into an electronic spread sheet. Current medication competencies for the RNs were evidenced. Attendance at training sessions has increased over the last three months.</p> <p>Three RNs are interRAI trained and have current competencies and two are currently completing the programme. There is at least one staff member on each shift with a current first aid certificate.</p> <p>Care staff on the night shift do not have 'second checker' competencies for controlled drug management. Not all care staff have current restraint competencies. None of the kitchen staff have completed a course in food safety.</p> <p>A New Zealand Qualification Authority education programme is available for staff who have not already completed the programme. Six of the eight staff working in the dementia unit have completed the dementia specific modules and the other two are enrolled.</p> <p>Staff performance appraisals were not current.</p> <p>Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation. Staff also confirmed their attendance at on-going in-service education but could not recall when their performance appraisals were last completed.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mix to</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>provide safe service delivery. The Ultimate Care Group electronic rostering tool is based on the handbook - Indicators for safe aged care and dementia care.</p> <p>There has been a focus on staffing levels since the previous surveillance audit. Interview of the FM and review of the rosters evidenced all positions have been filled. The FM advised there is now a waiting list of people who wish to work at the facility. Discussions with staff has occurred and staff are no longer working more than eight-hour shifts. The facility now has a pool of people to fill any gaps due to illness and the need to use agency staff has ceased. The FM reported the rosters are adjusted to meet the changing needs of residents, resident acuity including interRAI, occupancy and the environment.</p> <p>The FM and CSM work full time Monday to Friday and are on call after hours. Seven RNs are employed with another about to start employment. Registered nurse cover is provided seven days a week over the 24-hour period. Two RNs are on the morning and afternoon shifts and one is on at night. There is a mix of experienced RNs who have worked in the aged care sector prior to employment. One new RN has recently graduated and an overseas trained RN who has been working as a caregiver at Ultimate Care Ranburn has recently completed the Competency Assessment Programme (CAP) course and is now working as an RN. The registered nurses and the CSM reported they are making inroads relating to the clinical service and acknowledge there is still work to be done. Care staff spoke of situations where they felt they needed more staff to maintain safe care to residents and after discussions with the FM and CSM, hours have been increased. The FM and review of the rosters confirmed this.</p> <p>Staff interviewed demonstrated satisfaction with the staffing levels, that staffing has stabilised and they are no longer wanted to exit the service. The RNs and HCAs reported the CSM works with them and they feel supported and valued. The HCAs reported the RNs are leading the clinical teams and that they are more informed about resident cares. There are dedicated cleaning and laundry staff and some household staff have dual roles, for example, cleaning/kitchen hand. A diversional therapist and an activities coordinator who is currently completing the diversional therapy course provide planned activities (link to 1.3.7). A maintenance person works 32 hours per week and an administrator Monday to Friday. The kitchen has a chef working during the week with a cook on at the weekends and two kitchen</p>
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		<p>hands.</p> <p>Residents and families reported they have noticed an increase in staffing levels and are no longer concerned. The GP stated they are now happy with the level of care provided and have no concerns with regards to treatment orders being followed. Observations during this audit confirmed adequate staff cover is provided, including residents being helped with meals in a timely manner.</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 Low</p>	<p>The medication management policy was 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.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. All medications sighted were within current use by dates. Clinical pharmacist input is provided monthly.</p> <p>Controlled drugs are stored securely in accordance with requirements. The previous audit identified an area for improvement to ensure that a stock take of the controlled drugs is completed weekly and that all medication received by the facility is checked by a registered nurse. These corrective actions are now addressed, and records were available to demonstrate this.</p> <p>All registered staff who administer medicines are competent to perform the function they manage. Caregivers who are the 'second checkers' for controlled drugs administered on the night shift do not have a medication competency for controlled drugs (see criterion 1.2.7.5).</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 met. Standing orders (20) are used and have been signed for by the house GP.</p> <p>The previous audit identified an area for improvement to ensure that all three-</p>

		<p>monthly GP reviews are consistently recorded on the medicine chart. Review of the medication data base indicated that not all reviews were current at the time of the audit.</p> <p>The previous audit identified an area for improvement to ensure that an up to date assessment was provided to show that residents who self-administer medications are competent to do so. The corrective action is now addressed, and records were available to demonstrate that appropriate processes are in place to ensure this is managed in a safe manner. There were no residents who were self-administering medications at the time of audit.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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 by a qualified chef, cook and kitchen team, 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.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Ministry of Primary Industries and expires 26 June 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook and kitchen staff have not completed safe food handling training (see criterion 1.2.7.5).</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. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified through resident and family interviews, satisfaction surveys and resident meeting minutes. A corrective action plan is currently in place to ensure that all residents are satisfied with their meals.</p> <p>Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is 'safely provided'. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs, for example, district nursing services, an occupational therapist, physiotherapist, podiatrist, a high risk foot clinic service. Documentation, observations and interviews did not always verify that provision of care for residents was consistent with their needs, goals and the plan of care (please see criterion 1.3.3.1, 1.3.3.3, 1.3.3.4, 1.3.7.1, 1.3.8.2, 1.3.8.3, 1.3.12.1).</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>PA Moderate</p>	<p>The activities programme is provided by a trained diversional therapist holding the national Certificate in Diversional Therapy and an activities co-ordinator. The diversional therapist supports residents in the rest home and hospital area Monday to Friday 7.00 am – 3.00 pm. The diversional therapist oversees the activities co-ordinator who supports residents in the dementia unit Tuesdays and Thursdays 8.30 am – 4.30 pm. Wednesdays, Fridays and Saturdays 9.00 am – 1.00 pm.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements of all ages. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six-monthly care plan review.</p> <p>The previous audit identified an area for improvement to ensure that there are sufficient activities occurring in the secure unit. The corrective action has been partially addressed with the introduction of a new activities co-ordinator, but further improvements are required to ensure that activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there and that activities are offered at times when residents are most physically active and/or restless.</p> <p>The activities calendars for both the hospital/rest home and dementia unit showed a programme that reflected residents' goals, ordinary patterns of life and included normal community activities; however, not all residents have access to regular support from the activities team. Residents and families/whānau are involved in evaluating and improving the programme through day to day discussions. When interviewed, residents, families and staff reported that the programme is not always meaningful.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>The previous audit identified an area for improvement to ensure that evaluations are documented and/or indicate progress towards meeting the residents' desired outcomes, and when a resident's progress is different to that expected, the service responds by initiating changes to the service delivery plan. Further improvements are required to address the previous finding.</p> <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.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, wounds, weight loss and falls. Where progress is different from expected, the service does not always respond by initiating changes to the plan of care. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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 building warrant of fitness is displayed that expires on the 1 August 2019. There have been no structural alterations since the previous audit.</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 urinary tract infection, respiratory tract infection, skin, wound, eye, gastroenteritis and other infections. The IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>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 regular registered nurse meetings and at staff handovers, although this information is not included in care staff meetings (see criterion 1.2.3.6).</p> <p>The facility has had a total of 48 infections since June 2018 through to and including December 2019. A corrective action is in place to rectify under</p>

		reporting of infections. Residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Data is benchmarked externally within the organisation monthly. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint minimisation policy has a section on enablers that includes a definition, assessment and evaluation. The restraint coordinator, who is a RN, reported the aim is to have no restraint. There was one resident using a restraint at the time of audit and there were no residents using an enabler. Interventions for this resident were clearly documented in the care plan. Staff interviewed demonstrated good knowledge of the difference between a restraint and an enabler and the process should a resident request an enabler. Staff have received on-going education relating to challenging behaviours, enablers and restraint. (See criterion 1.2.7.5).
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 use of restraint for the one resident using restraint has been approved by the restraint approval group prior to commencing the restraint; this included the resident's GP. The GP completes three-monthly reviews of restraints in use. Responsibilities of the restraint coordinators and approval group are clearly outlined. The resident's file evidenced an 'Assessment and application for use of a restraint/enabler' form including the risks associated with the restraint used, consent and approval. Restraint use is discussed at the RN and staff meetings. Staff confirmed their knowledge of the restraint processes.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The file of the one resident using restraint was reviewed. Restraint assessment forms were completed prior to commencing restraint. Risk factors were identified in the assessment and the purpose of the chosen restraint was documented. The long term care plan evidenced comprehensive information relating to potential risks and interventions. Staff demonstrated knowledge in maintaining culturally safe practice when completing assessments for restraint use.
Standard 2.2.3: Safe Restraint Use	FA	A current and updated restraint/enabler register evidenced the one resident using restraint and discontinued restraint and enabler use.

Services use restraint safely		
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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 1.1.10.2</p> <p>Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.</p>	<p>PA Moderate</p>	<p>The clinical services manager knew the residents well and when interviewed could recall the proper procedures required for completion of resuscitation forms. One resident’s resuscitation form was signed by the GP but also had recorded ‘Not for resus as per EPOA (enduring power of attorney) orders’. A further three residents’ files (from the dementia unit) were also reviewed, the resuscitation forms were signed by the GP but also had stated ‘I do not want resuscitation attempts to be undertaken’ and was signed by the EPOA.</p>	<p>Four of eight residents’ resuscitation consent forms sighted in residents’ files were signed illegally by the enduring power of attorney.</p>	<p>Provide evidence that resuscitation consent is signed only by the GP in the event the resident is deemed incompetent to make an informed choice.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where</p>	<p>PA Low</p>	<p>Quality data for incident/accidents, satisfaction surveys, internal audits, infections, pressure injuries and medication errors are being collected, collated and comprehensively analysed to identify trends. Analysis, trends and corrective actions are reported back to the RNs</p>	<p>Apart from the RNs, quality data including analysis, trends and corrective actions is not being reported back to care staff.</p>	<p>Provide evidence that quality data is being reported back to all care staff.</p> <p>60 days</p>

appropriate, consumers.		through their meetings. Review of RN meeting minutes and interviews of RNs confirmed this. The RNs and CSM reported graphs of clinical indicators are provided at the meetings, however there was no evidence of this. The staff meeting minutes have no evidence of reporting back quality data to other care staff. Health care assistants reported they are not provided with any information or graphs relating to clinical indicators.		
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>The education programme is the responsibility of the facility manager. The programmes from 2018 and 2019 were reviewed and covers all essential subjects. Attendance records are held electronically and in hard copy. The FM reported they are trying different ways to encourage staff to attend the sessions and the attendance records evidenced an increase in staff attendance.</p> <p>There was no evidence of performance appraisals on the staff files reviewed. The FM has identified this and a current list evidenced several staff have performance appraisals dating back to 2015 and 2017. Staff interviewed could not remember when they last completed a performance appraisal. The FM reported the process to rectify this has been implemented.</p> <p>None of the kitchen staff have completed a food safety course and kitchen staff confirmed this.</p> <p>Documentation evidenced 12 care staff have a current restraint competency as well as those staff who have been employed</p>	<p>(i) Performance appraisals are not current.</p> <p>(ii) There is no evidence that kitchen staff have completed a food safety course.</p> <p>(iii) Not all care staff have current restraint competencies.</p> <p>(iv) The HCAs on night duty do not have competencies relating to checking out controlled drugs.</p>	<p>Provide evidence that: (i) performance appraisals are current for all staff; (ii) all kitchen staff have completed a food safety course; (iii) all care staff have current restraint competencies; (iv) the HCAs on night duty have current competencies relating to being a second checker for the management of controlled drugs.</p> <p>90 days</p>

		<p>within the last 12 months.</p> <p>The health care assistants (HCA) on the night shift do not have competencies for the role of 'second checker' for the checking out of controlled drugs.</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>	PA Low	<p>The facility is supported by one house GP and two other independent GP's in the community. Staff interviewed could recall the correct timeframes required for the three-monthly GP and medication reviews. The GP interviewed reported that care was 'safely provided' by staff at the facility. The electronic medication database showed that GP reviews for five residents and their medications were over due from January 2019.</p>	<p>Five GP three monthly reviews of residents and their medications are not up to date.</p>	<p>Provide evidence that all residents are seen at least 3-monthly by the GP and their medicines are reviewed to meet required timeframes.</p> <p>90 days</p>
<p>Criterion 1.3.3.1</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>	PA High	<p>Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and families confirmed their involvement in the assessment process.</p> <p>One resident was admitted to the rest home on the 31 January 2019 having been assessed as requiring rest home level of care. Due to wandering behaviour the night of admission, the resident was transferred to and remains currently in the dementia unit. The resident's EPOA was notified the following day. Progress notes reviewed showed that the clinical services manager requested that an interRAI assessment be updated but this did not occur. The needs assessment co-ordination service (NASC) was not informed. At the time of audit an interRAI assessment was being completed</p>	<p>Two residents admitted to the facility in February 2017 and January 2109 have not been assessed as requiring care.</p> <p>One resident assessed as requiring rest-home level of care is being cared for in the dementia unit.</p>	<p>Provide evidence that residents admitted to the facility have had an interRAI assessment, have been assessed by the NASC team as requiring the appropriate level of care and have been admitted to the right level of care at the facility.</p> <p>7 days</p>

		<p>to request a change in level of care.</p> <p>One resident was admitted to the facility on the 29 January 2019 having had an interRAI assessment in the community. At the time of admission, the resident did not have a confirmed level of care. An email showed that the NASC team was contacted on the 31 January 2019 requesting confirmation of the residents' level of care. An up to date interRAI assessment for the resident cannot be completed until the NASC team enters the resident onto the interRAI database and acknowledges a level of care for the resident. The resident has long term care plans in place.</p> <p>One resident admitted to the facility in February of 2017 is paying privately for their care. The resident has never had an interRAI assessment to determine their level of care required. Long term care plans show the resident to be independent with daily activities of living however documentation shows that the residents needs are changing and requires support from staff re: wound management.</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>	<p>PA</p> <p>Moderate</p>	<p>Registered nurses are responsible for all assessments and care planning. The clinical services manager who commenced her role in October 2018 has reviewed all resident's files to support staff to have completed each stage of service provision with the required timeframes. This information has been discussed with registered staff and sighted in staff meeting minutes. The clinical services manager has also created a cue sheet of questions to support the registered nurses when</p>	<p>Not all long-term care plans have been completed with the required time frames.</p> <p>Not all residents long term care plans reflect accurately current care and/or changes for the resident.</p> <p>Not all residents in the</p>	<p>Provide evidence that each stage of service provision is provided and documentation completed in full within the required timeframes to safely meet the needs of the resident.</p> <p>90 days</p>

		<p>completing the resident's long-term care plans. Residents interviewed stated that they had all their cares meet. Families interviewed stated that they were happy with the care provided at the facility.</p> <p>Three of nine residents' files reviewed did not have up to date long term care plans. An overall summarised internal audit last updated 8 February 2019 identified that three rest home, four hospital and three dementia residents long term care plans were also overdue.</p> <p>Two resident's files reviewed in the dementia unit did not have long term care plans to identify the residents challenging behaviours, triggers or interventions.</p> <p>One residents' file reviewed in the dementia highlighted that six of the eight documented challenging behaviours identified the date of the behaviour but did not record the time of the event. One resident admitted to the dementia unit assessed has having a rest home level of care had an initial behaviour chart completed on the night of admission, but this form has since not been used to record the residents' behaviour.</p>	dementia unit have had a completed behaviour monitoring chart.	
<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 Low	<p>Staff interviewed stated that with the new appointment of the facility manager and clinical services manager, there has been changes to the roster to support staff caring for the residents thus promoting a team approach. The GP interviewed stated that he has no concerns with communication with the staff at the facility and that care is 'safely provided'. Families interviewed stated they were informed of GP visits and</p>	<p>Two of nine resident's files reviewed did not have a summary of the GP visit.</p>	<p>Provide evidence of all GP visits in the residents' file.</p> <p>90 days</p>

		<p>the outcomes.</p> <p>Residents at the facility are supported by a house GP and two independent GP's in the community. Each residents file has a summary tracking dates when the resident has been reviewed by the GP. The clinical services manager interviewed stated that the GP sends thru a summary of their visit having seen the resident. The GP's documented report is kept initially in a folder at the facility for the GP to sign at their next visit. The record of the GP visit is then placed in the residents individual file.</p> <p>Two of nine residents' files reviewed did not have the most recent three-monthly review in the residents' file. A further two residents files reviewed did not have the initial GP admission notes. An internal audit (last updated 8 February 2019 summarised that 10 residents had been seen by the GP, but the residents' files did not have a copy of the GP notes. On the day of audit, the electronic medication device highlighted that five GP reviews remained overdue. The clinical services manager contacted the medical centre and was able to access the missing GP notes from the medical centre however the documents still required the signature of the GP.</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</p> <p>Moderate</p>	<p>All residents had a completed social profile and assessment. Families confirmed their involvement in the assessment process and care provided. Staff were observed at the time of audit to interact with residents in a way that highlighted that they knew the resident well. A daily record of the activities that the individual resident attends is</p>	<p>Activities provided at the facility do not always meet the needs of the resident.</p> <p>The 24-hour activity chart did not show all residents challenging</p>	<p>Provide evidence that the all residents are supported with regular activities that are meaningful to the resident.</p> <p>Provide evidence that all residents in the dementia unit have a 24-hour activity chart that identifies</p>

		<p>completed. The diversional therapist interviewed stated that there are five residents in the hospital that are socially isolated due to choose and/or medical reasons. These residents are visited and supported by the diversional therapist once a month.</p> <p>Two residents currently in the dementia unit had a 24-hour behaviour activity chart, but this chart did not evidence the residents' behaviour or interventions/activities known to reduce and/or minimise the risk of the behaviour.</p> <p>Interviews with staff, residents and families identified that not all activities in the facility are meaningful or age appropriate for the resident.</p>	<p>behaviours or activities to reduce and/or minimise the behaviour.</p> <p>Not all residents are receiving regular support from the activities team.</p>	<p>the resident's challenging behaviours and interventions to reduce and/or minimise the risk of the behaviour.</p> <p>60 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</p> <p>Moderate</p>	<p>All residents entered into the database have an up to date and current interRAI assessment by one of three interRAI trained assessors/ registered staff on site. Short term and wound management care plans are evaluated as required. Two of nine residents' files reviewed and an internal audit (last updated 8 February 2019) found that 10 residents' long-term care plans had not been evaluated in the last six months.</p> <p>One resident's long term care plan did not identify the residents' need for mobility equipment and supervision due to an increase in falls, a change in nutritional requirements due to a history of weight loss or evaluation of behaviours.</p> <p>Two residents in the dementia unit and one</p>	<p>Not all six-monthly evaluations of long-term care plans or behaviour monitoring charts are completed and/or up to date to meet the required timeframe.</p>	<p>Provide evidence that evaluations are documented and indicate achievement towards the desired goal.</p> <p>60 days</p>

		resident in the hospital have behaviour monitoring charts that have not been evaluated.		
<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>Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and family members interviewed stated that they were very happy with the care provided. Residents' progress notes detailed the residents' progress and highlighted any changes. One resident's long term care plans did not identify the resident's need for mobility equipment and supervision due to an increase in falls, a change in nutritional requirements due to a history of weight loss, evaluation of behaviours or change in medication.</p>	<p>Residents care plans do not always reflect accurately current care and/or changes for the residents.</p>	<p>Provide evidence of changes occurring to the care plans when progress is different to that expected for the resident.</p> <p>60 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.