

The Ultimate Care Group Limited - Allen Bryant Lifecare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	The Ultimate Care Group Limited
Premises audited:	Ultimate Care Allen Bryant
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 20 March 2017 End date: 21 March 2017
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	42

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
	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 Allen Bryant is a 46 bed rest home in Hokitika on the South Island's west coast. This service is owned by the Ultimate Care Group Limited. Forty two beds were occupied on the days of audit.

The certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. Audit processes used included review of policies and procedures, reviews of residents' and staff files, observations and interviews with residents, family, management, staff, an external health professional and a general practitioner.

Continuous improvement has been acknowledged for the implementation of emergency processes following recent floods. One area has been identified as requiring improvement, regarding police vetting and reference checking for new staff.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. Staff have received ongoing education on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).

Three residents at the facility identify as Maori. Services are planned to respect the individual culture, values and beliefs of all residents, including those who identify a Maori.

Residents, families and external health providers interviewed, stated that communication is excellent at this service. There was evidence that residents, families and other parties are provided with full and frank information in accordance with the principles of open disclosure. Appropriate written consents have been obtained.

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 national body is regular and effective. An experienced and suitably qualified person manages the facility.

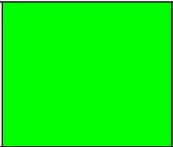
The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with

corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The 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.

A resident information management system is in place and information is entered in a timely and accurate manner. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Entry criteria for the facility is documented and available for any person and referral agency. The clinical services manager discusses any prospective referral with the referral agency to ensure admission is appropriate. If entry to the service is declined, a record is maintained.

Residents receive timely and appropriate services in order to meet their assessed needs and desired outcome/goals. Each stage of service provision is undertaken by suitably qualified and experienced staff competent to perform the function.

The processes for assessment, planning, provision, review, and exit are provided within timeframes that safely meet the needs of the resident and contractual requirements. Care plans are detailed and individualised, based on a comprehensive range of clinical information and the interRAI assessment. Short term care plans are developed to manage any problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes were identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a very high standard. Evaluation of care is consistently documented at least three monthly.

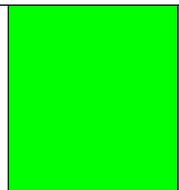
Residents are referred or transferred to other health services as required, with appropriate documented handovers.

The service provides an activities programme which reflects residents' preferences. The activities are planned and provided to develop and maintain skills and interests that are meaningful to the residents.

A medication management system is in place that meets all legislative and guideline requirements. Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage.

The menu has been reviewed by a dietitian as suitable for the older person living in long term care. Residents and family reported a high level of satisfaction with the meals and choices provided.

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

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

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

Restraint minimisation and safe practice

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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A documented restraint and enabler use policy is in place and meets the standard requirements. At the time of audit, there were no restraints in place and three residents who were using lap belts as enablers. All residents were able to remove their enablers without assistance.

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 clinical services manager is responsible for infection prevention and control and has a defined role to manage the environment and minimise the risk of infection to residents, staff and visitors. The service has a clearly defined and documented infection control programme that is reviewed at least annually.

Staff files, observation and interviews verified initial and ongoing infection control education occurs.

Surveillance for infection is conducted monthly and annually and transferred electronically to a data sheet. There is evidence of a continued reduction in infections and a proactive approach to continue this trend.

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	44	0	0	1	0	0
Criteria	1	91	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) was displayed in the communal area in the facility. Residents and family reported that they were provided with copies of the Code as part of the admission process.</p> <p>Staff demonstrated knowledge of the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents' rights.</p>
<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>	FA	<p>Files reviewed included appropriate written consents by the resident. Staff interviewed demonstrated good knowledge of consent processes. Families and residents interviewed verified appropriate consents occur as part of everyday practice, and this was observed during the audit.</p> <p>There was evidence in files of Enduring Power of Attorney (EPOA) input for those who could not consent themselves.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents and families interviewed reported that they were provided with information regarding access to advocacy services. Contact details for the Nationwide Health and Disability Advocacy Service was included in the admission package, with the brochure available at the entrance to the service. Education was conducted as part of the in-service education programme for staff. Staff demonstrated knowledge of advocacy processes.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Families reported that they are encouraged to visit at any time, and are always welcomed. Residents are supported and encouraged to access community services with visitors, or as part of the planned activities programme. There was evidence in residents' files that this occurs regularly. Staff were observed welcoming visitors and encouraging outings.</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. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Forms are available in the facility at all times.</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, are documented and completed within the timeframes. One complaint remains open and this is currently in the investigative process by the Health and Disability Commissioner and all requests for additional information have been responded to in a timely manner following the required process. Action plans show 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.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Family and residents interviewed reported that the Code was explained to them on admission, was included as part of the admission pack, and time was allowed for them to understand the information.</p> <p>Nationwide Health and Disability Advocacy service information is also included in the admission pack with brochures available at the entrance and communal areas of the facility. Residents and families interviewed reported that they were aware of their right to access advocacy services but they had not needed to do so.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and family interviewed reported that the residents are treated in a manner that shows regard for the resident's dignity, privacy and independence. Files reviewed indicate that residents received services that are responsive to their needs, values and beliefs.</p> <p>Residents, families, and one general practitioner (GP) interviewed did not express any concerns regarding abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There were three residents who identified as Māori at the time of audit. One resident and family member interviewed reported that there were no barriers to Māori accessing the service. Staff interviewed demonstrated a good understanding of services that are commensurate with the needs of Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents' files reviewed demonstrated consultation with the resident and family on the resident's individual values and beliefs. Families reported they were consulted with the assessment and care plan development. Staff interviewed demonstrated good knowledge on respecting each resident's culture, values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff employment documents had clear guidelines regarding professional boundaries. Families and residents interviewed reported they were very happy with the care provided. They expressed no concerns regarding breaches in professional boundaries and all reported a very high satisfaction with the caring, calming and professional manner of the staff.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>There were several examples of good practice implemented at Ultimate Care Allen Bryant. Evidence-based practice was observed, promoting and encouraging good practice. Engagement of external health professionals to support staff contributes to evidence based outcomes for residents.</p>

		The Clinical Services Manager (CSM) and all registered nurses (RN) are supported by Ultimate Care Group head office in ongoing professional development. Registered nurses are trained in interRAI assessments, except for the two most recently appointed. The organisation supported staff to attend pressure injury management training in 2016.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Staff demonstrated that they understand the principles of open disclosure. Residents, families and the GP confirmed they are kept informed of the resident's status, including details of events which may have affected the resident. Evidence of open disclosure was documented within each resident's file. All interviewees reported that communication was excellent. At the time of this audit there were no residents who required interpreter services to ensure effective communication. Both management and staff demonstrated their understanding of the organisation's processes for obtaining these services should they be required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	There is an organisation wide strategic plan. Each facility has a quality and business plan which links to the organisation-wide goals of the strategic plan. The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of quarterly reports to the national office showed adequate information to monitor performance is reported including occupancy levels and any emerging risks and issues. The service is managed by a facility manager who has significant experience in the sector and has been in the role for ten years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirms knowledge of the sector, regulatory and reporting requirements. The service holds contracts with DHB and the MoH for rest home and hospital services, YPD, respite and palliative care. 42 residents were receiving services under the contract (13 rest home, 22 hospital level care, four YPD and three palliative care) at the time of audit.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which	FA	When the facility manager is absent, the clinical services manager supported by the administration staff, carry out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by an experienced registered nurse who is able to take responsibility for any clinical issues that may arise. Staff reported the current

<p>ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>arrangements work well.</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>FA</p>	<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 patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, health and safety and staff training and education, that are all recorded on the organisation's electronic quality system. Regular reports generated include benchmarking with other facilities in the organisation and a large external provider.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators at both a national and local level. Related information is reported and discussed at the clinical, quality improvement team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through the internal audit activities and staff meeting discussions. 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 high level of satisfaction with the services provided. One issue raised was a request for the provision of a covered drive through area for picking up and dropping off residents that is protected from the weather. This has been included in the new capital expenditure budget.</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 are 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 facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</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</p>	<p>FA</p>	<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, analysed and reported to the national office by way of the electronic quality system.</p> <p>The facility manager described essential notification reporting requirements, including for pressure injuries. They advised there has been one notification of a significant event made to the Ministry of Health, since the previous audit. This was the evacuation in January 2017 due to a</p>

manner.		severe weather event warning which was well managed with no subsequent issues.
<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>	PA Moderate	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes 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, with the exception of getting the required number of references and consistent police vetting.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. They have a 'buddy' system in place and all new staff are monitored to identify when they are ready to work more independently. Staff records reviewed show documentation of completed orientation and a performance review after a six month 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 and the organisational requirements. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and 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>	FA	<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. 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 usually adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a six week roster cycle 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 24/7 registered nurse (RN) coverage in the hospital.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p>	FA	<p>All required details are used on labels as the unique identifier on all residents' information sighted. All necessary information was fully completed in the residents' files sampled for review.</p>

<p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. Archived records are held securely on site and are readily retrievable using a cataloguing system.</p>
<p>Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The clinical services manager (CSM) logs enquiries and documents interview responses to gauge if the prospective resident is suitable for the facility. The residents are required to have an assessment for rest home level of care. The CSM reported that she communicates regularly with referring agencies to ensure admissions are appropriate for the facility.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>When admission is required to another provider (for example a higher level of care), the service completes a transfer form. The referral process documents any risks associated with each resident's transition, exit, discharge, or transfer. With the transfer form, the RN also provides a copy of any other relevant information, such as the medication chart. A file of the one resident reviewed with a recent transfer to another provider evidenced that the transfer was effectively managed.</p>
<p>Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>All aspects of medicine management are being undertaken according to medicine management policies and procedures, legislative requirements and the Ministry of Health guidelines for the management of medicines in aged care facilities.</p> <p>Most medicines are supplied by the pharmacy in a blister pack administration system. The medicines that are not pre-packed, such as liquid medicines, are individually supplied for each resident. The medicines and pre-packed medicine sheets are checked for accuracy by the RN when delivered. The pre-packed medicines and the signing sheets are compared against the medicine prescription. The GP conducts medicine reconciliation on admission to the service and when the resident has any changes made by other specialists.</p> <p>Safe medicine administration was observed at the time of audit. All records were accurately completed.</p> <p>The medicines and medicine trolley were securely stored. The fridge where medicines are stored was monitored for temperature, with the sighted temperatures within medicine storage guidelines. Any controlled drugs were stored in a locked safe in a secure room.</p>

		<p>All the medicine charts sighted had prescriptions that complied with legislation and aged care best practice guidelines. The medicine charts recorded the regular, short course and pro re nata (PRN – as required) medicines for each resident. When medicines were discontinued, these were crossed out and signed and dated by the GP. The medicine charts sighted had a current photo of the resident and recorded any medicine related allergies. Sample signature verification was recorded for all staff who administer medicines. All of the medicine charts were reviewed by the GP in the past three months.</p> <p>Medication competencies were sighted for all staff that assist with the medicine management; this included the RN.</p> <p>There was one resident self-administering medication, and this was in accordance with the organisation's policies and procedures.</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>A cook manages the kitchen and was unavailable for interview during the audit. The relieving cook however was interviewed. The current menu was reviewed by a dietitian as being suitable for the older person living in long term care. If there are changes to the menu these are recorded and referred to the dietitian at the next review. A note book recorded any changes. All residents and families interviewed were very satisfied with the food and food services.</p> <p>Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met.</p> <p>There is food available at any time for those who wish to snack at night.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines. Fridge and freezer recordings were undertaken daily and meet requirements. All foods sighted in the freezer were in their original packaging or labelled and dated if not in the original packaging. Evidence was seen of all kitchen staff having completed safe food handling certificates.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where</p>	<p>FA</p>	<p>The CSM reported that she has not declined entry to any potential residents who have an appropriate needs assessment prior to admission. She confirmed that if entry to the service was to be declined the referrer, potential resident and where appropriate their family, would be informed of the reason for this and of other options or alternative services.</p> <p>The facility's admission agreement contained information on the termination of the agreement. This documents that if a resident's needs changed and if the service can no longer provide a</p>

appropriate.		safe level of care to meet the needs of the resident, they would be reassessed for the appropriate level of care.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The service has fully implemented the interRAI assessment tool for all residents, and all assessments are current. The RN during interview demonstrated the links between interRAI, planning and reviews. Care plans sighted reflected the needs of the residents as identified in the interRAI assessment tool. All residents' physical, psycho-social, cultural and spiritual needs were fully documented as part of the assessment process. Goals are individual and consistent with meeting the outcome needs of the residents and the scores indicated in the interRAI. A GP during interview confirmed that assessments were always timely and appropriate.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans sighted were of a very high standard, reflected the interRAI triggers, and were comprehensive and up to date. Short term care plans were developed to manage any problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is consistent across care staff. Integrated files had one main folder that contained the medical information, nursing assessment, care plan, routine observations, activities, therapies, family correspondence and specialist consultations. Staff interviewed confirmed they were well informed and care plans were very clear and they were involved in the review process. The GP interviewed expressed a high level of satisfaction with the care provided, and noted the service looked after palliative residents particularly well. This was re-iterated during interview with the palliative care outreach nurse.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet	FA	Services are being delivered according to information in resident's individualised care plans. Short term care plans are being developed for short term problems, such as skin tears, wounds, decreased mobility and infections. Progress notes reviewed demonstrated that care and support was consistent with the identified problems, personal goals and interventions, as described in

<p>their assessed needs and desired outcomes.</p>		<p>the care plans.</p> <p>Staff informed that they report any concerns about a resident, such as a change in their condition, both in the progress records and to the RN, and this was confirmed in documentation reviewed and interviews with the CSM and RN.</p> <p>Families and residents spoke very highly of the level of care and support provided and consistently stated that all of their needs were being met. The GP interviewed confirmed that his interventions ordered were always implemented.</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>On admission, a personal profile is completed for each resident. A detailed and individualised activity plan is developed and updated during review. A range of activities are planned for each month and copies of the monthly activity schedules showed that options were varied.</p> <p>One activities person and two volunteers implement the activities programme. During interview the activities person reported that options for group activities were discussed regularly with residents and family.</p> <p>Residents and families reported they were very happy with the activities available. They confirmed there is no compulsion to attend, or participate if they are in the lounge during activity time. Residents who wish are assisted to undertake activities on a one to one basis and a record of this was retained.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Evaluation of both short and long term care plans was occurring within recommended timeframes with detailed outcomes/goals included. Six monthly reviews of care plans were occurring. Both residents and family were consulted and informed when changes are identified. This was confirmed during interviews and via the family communication forms.</p> <p>Information was being included in progress notes and changes were being made to interventions on care plans when indicated. Staff interviewed stated they are consulted prior to evaluations.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service</p>	<p>FA</p>	<p>The GP arranges for any referral to specialist medical services when it is necessary. The residents' files reviewed had appropriate referrals to other health and diagnostic services. The RN confirmed that they utilise external services as much as possible. Referrals were sighted for consultations with general medicine, pathology, dietitian and radiology services. The GP interviewed reported that appropriate referrals to other health and disability services were well</p>

providers is appropriately facilitated, or provided to meet consumer choice/needs.		managed at the service.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 30 June 2017) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio-medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes one room with an ensuite and two with shared ensuites. All showers are able to accommodate shower beds and all rooms have their own hand basins. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
Standard 1.4.4: Personal Space/Bed	FA	Adequate personal space is provided to allow residents and staff to move around within their

<p>Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>bedrooms safely. All bedrooms provide single accommodation. Rooms were personalised with furnishings, photos and other personal items displayed.</p> <p>There is ample room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry by designated staff. The laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry was managed well and their clothes returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and recent audit and observations on site confirmed a high standard was maintained for both service areas.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 22 July 2010. A trial evacuation takes place six-monthly, is managed by an independent contractor with the most recent being on 13 March 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets and first aid supplies were sighted and meet the requirements for 46 residents. Water storage tanks are located around the complex and each room has a small supply of water. There is a generator on site. Emergency lighting is regularly tested.</p>

		<p>Call bells alert staff to residents requiring assistance. Residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time each night. After-hour's access is by way of a bell at the main entrance.</p> <p>A continuous improvement is awarded for the development of improved evacuation procedures following an evacuation in 2015.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and large opening external windows. Heating is provided by electric panel heaters and underfloor heating in residents' rooms. Heat pumps have been installed in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control (IC) RN is the CSM and was interviewed. The job description for the infection control nurse role is defined. There are clear lines of accountability for infection control matters at the service through the staff meetings. The CSM attends these meetings and provides a report to the all other meetings on IC matters.</p> <p>The annual review of the infection control programme has been conducted within the past 12 months.</p> <p>The service has policies about staff, residents and visitors suffering from, or exposed to and susceptible to, infectious diseases. Staff reported that they do not come to work if they are unwell. Notices are placed at entrances to ask visitors not to visit if they are unwell, or have been exposed to others who are unwell. There was sanitising hand gel throughout the service for residents, visitors and staff.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The CSM attends ongoing education. She reported that the facility can access external advice from the hospital IC consultant, the GP, DHB and Ministry of Health services as required. Infection control is discussed at the staff and quality meetings and staff education occurs annually and randomly as part of the on-site audit process and as required at handover meetings.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>Ultimate Care Allen Bryant uses the Ultimate Care Group's organisation-wide detailed policies and procedures. Staff demonstrated good infection prevention and control practices reflective of policy. These have been designed to be fit for purpose and include best practice for Ultimate Care Allen Bryant's residential care environment.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Infection control education is provided by the CSM who has maintained her knowledge of current practice. The in-service education programme contained education and attendance sheets for IC education sessions. These sessions were referenced to current accepted good practice. Infection control practices are included in induction and orientation for all new staff.</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>The CSM was interviewed in relation to surveillance activities. Monthly and annual analysis of infections are occurring at head office via an electronic system, and reported six monthly to staff and quality meetings. Infection surveillance records reviewed showed a consistent low incidence of infections over the past year. The facility was proactively implementing measures to continually reduce infections. Training and recommendations were put in place when any infections occur to assist in minimising infection rates.</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>The organisation has well documented policy and procedure for the minimisation of and the use of restraint. Staff receive yearly education on de-escalation and challenging behaviours. At interview, the restraint coordinator confirms this is the case.</p> <p>At the time of audit, no restraints were used at the facility. There had not been any resident using restraint and the register and minutes of restraint meeting were sighted to confirm this. There were three residents who were recorded as using lap belts as enablers, however not all documentation had been completed. The information provided was that all three residents were able to undo the lap belts themselves and were subsequently entered into the restraint register as using voluntary enablers.</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)
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Moderate	A review of files evidenced that police vetting and reference checks were not consistently being completed and documented. The organisational policy requires a police vetting check to be made as soon as possible following appointment and that appointment is conditional on a favourable result being received. Two of the three latest appointments have not had the required police vetting completed. Two reference checks are also required and in most files reviewed only one had been completed. No concerns have been identified with any of the staff appointments.	Police vetting and reference checks for all new staff are not being completed in a timely manner and documented in line with the organisation's policy and procedural requirements.	Ensure all documentation and police vetting is completed as soon as possible after conditional appointments are made and two reference checks are completed prior to any offer of employment. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security</p>	CI	<p>An emergency evacuation in June 2015 was required due to extensive flooding following a weather event in the area. The evaluation of the evacuation identified that, while it adequately met all requirements, if the evacuation had been made earlier, it would have minimised potential hazards and risks. This included the stress on both residents and staff and the pressure of moving a large number of residents to alternative accommodation. Key improvements were made ensuring decisions surrounding whether to evacuate or not could be made well in advance. A working group was formed with local emergency services and the DHB with a plan put in place to respond earlier to any severe weather warning that may indicate an evacuation could be needed. In addition, a new resident register was developed which would enable the team to immediately have a quick snapshot of the resident and the level of assistance required, while also enabling the manager to work remotely from the emergency evacuation point. In January 2017, this plan was tested following a severe weather warning and the subsequent decision made in conjunction with the National Office, local emergency services, the local GP and the DHB to evacuate the facility as a precautionary measure. This was carried out in a well-planned, calm and controlled manner from the planning throughout the day, until the evacuation commenced at 5.30pm. This proved to reduce the margin of error and potential risk to residents. Feedback following the evacuation from families,</p>	<p>A quality initiative was initiated following the June 2015 flood that resulted in an evacuation of the facility in the middle of the night. Work commenced on improving the evacuation procedures at the facility to ensure that any future evacuations were performed at an even higher standard and all possible risk to</p>

<p>situations. This shall include fire safety and emergency procedures.</p>		<p>the Mayor of the district and the local emergency services was very positive and praised the work of the organisation who had managed the process without requiring the assistance from local emergency services. A subsequent evaluation meeting of the working group has confirmed the new process was very successful and work will continue to develop those key relationships and identify other variables that could be further improved and incorporated into future planning.</p>	<p>residents was eliminated. A subsequent response to a recent severe weather warning confirmed the new evacuation procedures were successful in reducing stress and minimising risk and potential hazards.</p>
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End of the report.