

The Ultimate Care Group Limited - Ultimate Care Manurewa

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 Central Region's Technical Advisory Services 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 Manurewa
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 17 September 2019 End date: 18 September 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:	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 Manurewa is part of the Ultimate Care Group Limited. The facility is certified to provide services for 51 residents requiring rest home or hospital level of care. There were 42 residents at the facility on the first day of the audit.

This certification audit was conducted against the Health and Disability Service Standards and the facility's contract with the district health board.

The audit process included the review of policies and procedures, review of resident and staff files, and observations and interviews with family, management, staff, and a general practitioner.

There were areas identified as requiring improvement at this audit relating to observations following an unwitnessed fall and required timeframes for care planning and admission agreements.

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.
--	--	--

Information regarding the Health and Disability Commissioners' Code of Health and Disability Consumers' Rights; the complaints process; and the Health and Disability Advocacy Service is made available to residents and their families on admission and is accessible to residents and their families in the facility.

Staff interviews demonstrated an understanding of residents' rights and obligations. Residents and family members confirmed their rights are being met.

Residents' cultural and spiritual beliefs are identified on admission and there is access to cultural and spiritual support if required. Informed consent is practised and written consent is obtained when required.

Services are provided that respect the independence, personal privacy, individual needs, and dignity of residents. Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse and neglect.

Staff communicate with residents and family members following incidents and this is recorded in the resident's file. Interviews with residents, family and the general practitioner confirmed that the environment is conducive to communication, that issues are identified where applicable, and that staff are respectful of residents' needs.

There is a documented complaints management system that aligns with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. Complaints are investigated and documented, with corrective actions implemented where required. A complaints register is maintained. There have been no complaints to external agencies since the last audit.

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 low risk.
---	--	---

The Ultimate Care Group Limited is the governing body responsible for the services provided at Ultimate Care Manurewa. The mission, values, and goals of the organisation are documented and communicated to all concerned.

The facility has implemented the Ultimate Care Group Limited's quality and risk management system that supports the provision of clinical care and quality improvement meetings. Meetings are held that include reporting on various clinical indicators, quality and risk issues, and discussion of identified trends.

The facility has an incident and accident management system to record and report adverse, unplanned or untoward events, including appropriate statutory and regulatory reporting.

Ultimate Care Manurewa is managed by an appropriately qualified facility manager who is responsible for facility management and is supported by the regional operations manager. The facility manager is also supported by the clinical services manager who is a registered nurse and is responsible for clinical management and oversight of services.

The Ultimate Care Group Limited's human resource policies and procedures guide practice and there is evidence that human resource processes are being followed. There is a role specific orientation programme and ongoing training is provided. There is a documented staff allocation process in place to ensure optimal cover with appropriately skilled, educated and qualified staff. Staffing levels are adequate across the services.

Systems are in place to ensure the consumer information management system is protected from unauthorised access.

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 low risk.
--	--	---

Where the progress of a resident is different from expected, a short-term care plan is completed for short-term problems. The residents and the family members have an opportunity to contribute to assessments, care plans and evaluation of care.

The planned activities are appropriate to the group setting, and young people with disabilities have additional activities to address their social needs. The residents and families interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

There is an appropriate medicine management system in place. Staff responsible for medicine management attend medication management in-service education and have current medication competencies. There were four residents self-administering medicines.

Food and nutritional needs of residents are provided in line with recognised nutritional guidelines. There is a central kitchen and on-site staff that provide the food service. The kitchen staff have completed food safety training. Residents have choices and can make input into menu changes.

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.
--	--	--

There is a current building warrant of fitness and an approved fire evacuation plan. Essential emergency and security systems are in place to ensure resident safety. Six monthly trial evacuations are undertaken.

A planned, preventative and reactive maintenance programme is in place that complies with legislation and includes equipment and electrical checks.

Residents' rooms provide single accommodation and are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Bathroom and showering facilities are provided throughout the facility and are easily accessible. The facility has a monitored call bell system for residents to summon help, when needed, in a timely manner.

There are documented and implemented policies and procedures for cleaning and waste management. Cleaning and laundry services, provided seven days a week by household staff, are monitored.

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 uses the Ultimate Care Group Limited policies and procedures for restraint minimisation and safe practice, meeting the requirements of the standard. There are systems in place to ensure assessment of residents is undertaken prior to restraint or enabler use. The restraint coordinator confirmed that enabler use is voluntary.

There were two residents using restraint and two residents using enablers on audit days.

The residents' files reviewed demonstrated that the service focuses on de-escalation processes, and restraint and enabler use is documented in residents' care plans.

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.
---	--	--

The infection prevention and control policies and procedures include guidelines on prevention and minimisation of infection. New employees are provided with training in infection control practices and there is ongoing infection control education available for all staff.

The infection control surveillance data confirmed that the surveillance programme is appropriate for the size and complexity of the service. The surveillance of infections is occurring according to the infection control programme. The surveillance data is collated, analysed and benchmarked within the organisation.

There have been no outbreaks since the previous audit.

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	48	0	2	0	0	0
Criteria	0	99	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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 organisation has implemented policies and procedures to ensure that services are provided in a manner that is consistent with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>All staff have received education on the Code as part of orientation and the annual core education programme. Staff interviews confirmed their understanding of the Code and described practices that evidence an understanding of their obligations. Evidence that the Code is implemented in their everyday practice includes but is not limited to: maintaining residents' privacy; providing residents with choices; addressing residents by their preferred name; facilitating the maintenance of community linkages; involving family and residents in decision making; and ensuring residents are able to practise their own personal values and beliefs.</p> <p>Resident and family interviews, and observation, confirmed that services are provided in a manner that upholds resident dignity and maintains their privacy. Staff are respectful towards residents and their families and resident interviews confirmed they receive information relevant to their needs.</p>
<p>Standard 1.1.10: Informed Consent Consumers and where appropriate</p>	FA	<p>The organisation's informed consent policy ensures that a resident who has the capacity/competence to consent to treatment/procedure is given sufficient information to make an</p>

<p>their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>informed decision. Cultural considerations are identified such as whānau support and involvement in decision making. The policy provides a definition of consent and procedures as to how this will be facilitated and obtained. The policy outlines how staff are to obtain documented consent. when a resident is unable to make their own decisions, consent in an emergency, treating without consent, the right to refuse medical treatment, advance directives and do-not-resuscitate orders. The policy also ensures that informed consent is obtained on a regular basis and outlines that residents are provided the opportunity to participate in or decline activities.</p> <p>The information pack provided on admission includes information regarding informed consent. The facility manager or registered nurse (RN) discusses this with family and the resident during the admission process to ensure understanding. Staff receive orientation and training on informed consent and staff interviews confirmed that they are aware of the informed consent process.</p> <p>There is a resuscitation and advance directives policy to ensure that the rights of the resident are respected and upheld, and residents are treated with respect and dignity during all stages of care, including serious illness. The policy defines an advance directive and do not resuscitate order and the procedure for initiating and documenting these. File reviews demonstrated that advance directives and resuscitation orders were completed in accordance with policy. Four of eight (50%) resident files reviewed demonstrated evidence of a completed advance directive.</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>There is a resident advocacy policy to ensure that the Code is upheld and that residents have access to representation. It details the procedure for staff to follow to ensure that residents and their families/enduring power of attorney have access to appropriate representation. It includes advocacy services and supports access to advocacy services. Information regarding the availability of the Nationwide Health and Disability Advocacy Service is included in the information packs provided to residents and family prior to or on admission to the facility. Additional advocacy services brochures were observed in prominent places across the facility. The complaints policy also includes contact details of the Nationwide Advocacy Service for assistance and support if required.</p> <p>Staff receive training on advocacy as a component of the annual core training programme.</p> <p>Interview with the facility manager confirmed that in addition to the Nationwide Health and Disability Advocacy Service, all residents can access advocacy services through the local marae if required.</p> <p>Interviews with residents and family confirmed that they are aware of the right to advocacy and that advocacy services are available.</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>Observations and family and staff interviews confirmed that residents have access to visitors of their choice. There are areas where a resident and family can meet in private. Interviews with residents and family and observation, confirmed that families are welcome in the facility and are free to visit at any time.</p> <p>Interview with residents, families and staff confirmed that residents are free to leave the facility and do so to be involved in family events, visit local clubs and events. Interviews with younger persons with disabilities (YPD) residents, by the consumer auditor, confirmed that access to family and friends is promoted and that they enjoy attending club activities within the community on a regular basis.</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 organisation's complaints policy and associated procedures outline the complaints process that is in line with Right 10 of the Code. The policy includes the expected timeframes for responding to a complaint. The complaint process is made available as part of the information pack and explained by the facility manager or RN on admission. The complaint forms are also available at the entrance to the facility.</p> <p>The facility manager is responsible for managing complaints. There had been three complaints since the previous audit. An up-to-date complaints register is in place that includes the date the complaint is received; the source of the complaint; a description of the complaint; resolution and the date the complaint is signed off. Evidence relating to each lodged complaint is held in the complaints folder and register. Interview with the facility manager and a review of complaints indicated that complaints are investigated promptly, and issues are resolved in a timely manner.</p> <p>Interviews with the facility manager, staff and residents confirmed that residents are encouraged to raise any concerns and provide feedback on services. Resident and family interviews confirmed that they are aware of the complaints process. Residents and family stated that they could raise any issues directly with the facility manager and that these are dealt with effectively and efficiently.</p> <p>There have been no complaints to external agencies since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>New residents and their families are provided with information about the Code as part of an information pack provided prior to or on admission to the facility. The Code is also discussed with the resident and family during the admission process to ensure understanding. The pack includes information on the complaints process and advocacy service.</p> <p>The Code and associated information are also available in information brochures, which are</p>

		displayed throughout the facility and available to take away and read in private. Information on the Code is also displayed in posters in English and te reo Māori throughout the facility.
<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>The organisation has guidelines that describe how the facility will meet the requirements of the privacy act, and health information privacy code ensuring that a resident's right to privacy and dignity is upheld. Staff receive training in privacy and confidentiality as a component of the annual core training programme.</p> <p>Resident, family and staff interviews, and observation, confirmed that staff knock on bedroom and bathroom doors prior to entering, ensure that doors are shut when personal cares were being provided and residents are suitably attired when taken to bathrooms. Interviews and observation confirmed that conversations of a personal nature were held in private, and confidentiality was maintained. Resident and family member interviews confirmed that resident privacy is respected.</p> <p>The organisation has a policy on sexuality and intimacy to ensure that the resident's needs are accepted and met within guidelines. It acknowledges a resident's right to express their sexuality and includes strategies to assist residents to feel comfortable about expressing their sexuality. The cultural safety policy assessments include identifying resident preferred customs and use of cosmetics and hair cares. Staff interviews confirmed that they assisted residents to choose their own clothing to wear each day. Resident interviews and observation confirmed that residents could wear clothing and adornments of their choice each day.</p> <p>Resident files reviewed, staff, and family interviews confirmed that individual cultural, religious, social preferences, values and beliefs were identified, documented and upheld.</p> <p>There is an elder abuse and neglect policy to ensure that residents are protected from abuse and neglect. It details the responsibilities of staff to report suspicions or observations of abuse and neglect, expectations of resident care and treatment, and provides definitions of abuse and neglect. Staff receive orientation and annual core training on abuse and neglect. Staff interviews identified that staff are aware of their obligations to report any incidences of suspected abuse. Staff, resident and family interviews confirmed that there was no evidence of abuse or neglect. There were no documented incidents of 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</p>	FA	<p>The organisation has a Māori health policy that demonstrates Ultimate Care Group's (UCG) recognition of the principles of the Treaty of Waitangi. It describes how UCG will respond to Māori cultural needs and beliefs and provide a culturally appropriate service to Māori residents and their whānau.</p>

<p>met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>Interview with the facility manager confirmed that support for staff in providing culturally appropriate care, and for Māori residents and their families, is sourced if required through a local marae that the facility accesses for external activities and a district health board (DHB) kaumātua. Staff receive training in the Treaty of Waitangi and cultural safety as a component of the annual core education programme. There were six residents who identified as Māori at the time of audit.</p> <p>Resident interviews confirmed that whānau involvement in care is facilitated.</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>	<p>FA</p>	<p>There is a cultural safety policy that describes for staff how culturally competent services should be delivered. Staff, resident and family interviews confirmed that residents are provided with choices regarding their care and the services provided, and that residents and family are involved in assessment and care planning processes.</p> <p>On admission each resident's ethnicity and specific cultural beliefs and values are identified and documented in their individual care plan. Information gathered during assessments includes identifying a resident's specific cultural needs, spiritual values and beliefs. Assessments also include obtaining background information on a resident's spiritual and cultural preferences, which includes but is not limited to: religious observances/ethical values; customs, access to spiritual advisors, and special possessions of cultural significance. This information informs activities that are tailored to meet identified needs and preferences.</p> <p>For those residents who chose to attend, a Baptist church and a Māori Christian service provide two interdenominational religious services each week. Blessings are undertaken of a room following the death of a resident.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>There are policies to ensure that the environment for residents is free from discrimination; coercion; harassment; and financial exploitation.</p> <p>Job descriptions include the responsibilities and accountabilities of the position, including the expected professional conduct relevant to each role. Staff interviews confirmed awareness of their obligation to report any evidence of discrimination, abuse and neglect, harassment and exploitation.</p> <p>There were no documented complaints or incidents recorded since the previous audit relating to any form of discrimination, coercion or harassment.</p> <p>Staff are required to sign and abide by the UCG code of conduct and declaration policy that sets out the expected minimum standards of integrity and conduct. The staff annual training programme</p>

		includes customer service and professional boundaries. Staff interviews confirmed their understanding of professional boundaries relevant to their respective roles. Interviews with residents and families confirmed that staff maintain appropriate professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The facility implements the UCG policies and procedures which are current and based on good practice current legislation and guidelines. The policies align with the Health and Disability Services Standards and ensure safe, current evidence-based practice.</p> <p>There are relevant training programmes for all staff. The facility manager enters facility data onto the UCG electronic database. Data is measured against industry thresholds and benchmarking occurs across all UCG facilities. The regional clinical quality manager and the clinical quality advisor review all data weekly. There is regular telephone contact and at least monthly face to face contact between the facility manager and the regional operations manager, ensuring performance measures and data are discussed. Staff interviews and monthly meeting minutes identified that the results of benchmarking are made available to and are discussed with staff.</p> <p>Staff, resident and family interviews, residents' file notes and observation of service delivery confirmed that resident care was based on good practice guidelines.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>There is an open disclosure policy that promotes a transparent, consistent approach to full and open disclosure where there is an instance of actual or potential adverse event and or harm during the course of a resident's care. Completed incident forms, residents' records and resident and family interviews demonstrated that family are informed if the resident has an incident/accident; a change in health or a change in needs. Family contact is recorded on incident forms and in residents' files.</p> <p>Staff, resident and family interviews confirmed that family are included where appropriate in resident care planning meetings. Three monthly resident meetings inform residents of facility activities. Three monthly family meetings are also offered for family. Meetings are advertised on the facility notice board and in the previous meeting minutes. Meetings provide an opportunity to provide feedback and raise and discuss issues/concerns with management. Minutes of the family meetings sighted provided evidence that a range of subjects are discussed such as, but not limited to: new residents and staff; facility improvements; activities; and health and safety relevant to residents. Copies of the meeting minutes are made available to residents following each meeting, which are confirmed and signed as accurate by a resident. Copies of the activities programme and menu are also available to residents and families.</p>

		<p>Resident and family interviews and observation confirmed that the facility manager was approachable and available to discuss issues and that the facility manager addressed concerns and queries promptly.</p> <p>Residents who do not use English as their first language are offered interpreting services. Interview with the facility manager confirmed that interpreter services are available to the facility through the DHB. Staff represent a number of ethnicities and can communicate with residents in their native tongue if the resident wishes, these include: Samoan; Tongan; Fijian Indian; and Māori. At the time of the audit there were three residents who required assistance with interpretation. Family members and staff were available to interpret for two residents and for one resident a translation board and an electronic translator were used to facilitate communication.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The facility is part of the UCG with the national support office providing support to the facility. Communication between the service and the support office, via the regional operations manager occurs at least weekly. The regional operations manager and the regional clinical advisor provided support during the on-site audit. The weekly facility report provides the national support office with progress against identified indicators.</p> <p>Ultimate Care Manurewa has a documented mission statement, vision and values, that reflects a person/family centred approach to resident care.</p> <p>There is an overarching UCG quality and risk management plan that includes business planning expectations of the facility. Ultimate Care Manurewa has a current business plan that sets out the direction of the facility.</p> <p>The facility is managed by a facility manager who has been in the current role for two years and had previously been the facility manager for six years prior before leaving to work in general practice administration. The facility manager also has nine years previous experience as a caregiver with this facility. The facility manager has completed training through the Employers and Manufacturers Association.</p> <p>The clinical care at the facility is currently overseen by the clinical services manager (CSM) who is supported by a team of RNs. The CSM has been in the role for 10 months and has five years' experience as a RN, including two years at this facility. Both the facility manager and CSM have completed an orientation relevant to their roles.</p> <p>The senior team is supported in their roles by the regional operations manager and the regional clinical advisor.</p> <p>The facility is certified to provide rest home care for up to 51 residents. There were 42 beds</p>

		<p>occupied at the time of the audit, this included 28 residents who had been assessed as requiring hospital level care and 14 residents assessed as requiring rest home level care. These numbers included: one resident under the long-term chronic conditions (LTCC) contract who was under 65 years of age and four residents under the YPD contract, two of whom had been assessed at hospital level of care and two at rest home level care. The facility has contracts with the DHB for the provision of rest home and hospital level care; YPD, LTCC and respite care.</p> <p>The facility does not have any occupancy rights agreements.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence of the facility manager, the CSM, with support from the regional operations manager is the person designated as responsible for the day to day operation of the service. A roving UCG facility manager is available to step into the role for longer facility manager absences.</p> <p>In the absence of the CSM, another RN with the support and help of the regional clinical advisor will ensure continuity of clinical services.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The facility utilises UCG's documented quality and risk management system to guide service delivery.</p> <p>All policies are current and align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. Policy and procedure documents are reviewed at an organisational level with input from relevant personnel. New and revised policies are presented to staff at staff meetings and made available to staff to read. Staff sign an acknowledgement form to confirm understanding of an agreement to comply with the changes in a policy or procedure. Staff interviews confirmed that they are advised of and have read the new or revised policies.</p> <p>The service delivery is monitored through the organisation's reporting systems utilising several clinical indicators such as: skin tears; falls; weight loss; infections; restraints and enablers; medication errors and pressure injuries. Monthly facility quality meetings include input from activities such as health and safety, internal audits and surveys. There was evidence that the annual internal audit programme is implemented as scheduled. Quality improvement data sighted provided evidence that data is being collected and collated with the identification of trends and analysis of data. Corrective action plans are developed, implemented, evaluated and signed off for quality activities such as audit findings and incidents and accidents. There is communication with staff of any subsequent changes to procedures and practice through monthly meetings.</p> <p>Facility meetings such as RNs, health and safety, diversional therapy and quality are held</p>

		<p>consecutively on the same day to facilitate attendance for staff. Quality committee meeting minutes evidenced all aspects of quality improvement; risk management; and clinical indicators are discussed. Staff reported that they are kept informed of quality improvements.</p> <p>Residents are notified of relevant updates such as facility improvements and health and safety, through the facility's resident meetings. Interviews with YPD residents confirmed that they have the opportunity to attend and have input into these meetings. Satisfaction surveys for residents and family are completed as part of the internal audit programme. Corrective actions, such as laundry services and these are presented and discussed at resident meetings. The results of the last completed survey in September 2018 reviewed, evidenced satisfaction with services provided and this was confirmed by family interviews. Corrective action plans had been developed for three areas for improvement arising from this survey, with two implemented and closed out and one still in progress.</p> <p>The organisation has a risk management process in place that records the management of risks by category. Health and safety policies and procedures are documented along with hazard identification, assessment and management processes. Health and safety is monitored as part of the annual internal audit programme. Staff receive orientation and education on health and safety. Staff interviews confirmed an awareness of health and safety processes and of the need to report hazards, accidents and incidents promptly. Health and safety events such as: hazards; policy and procedures; and training are discussed at health and safety meetings and shared with staff at staff meetings.</p> <p>The facility manager and one other staff member are the health and safety representatives. Both staff members have signed health and safety position descriptions that describe the accountabilities of the role. Interview confirmed a clear understanding of the obligations of the role and health and safety. There was evidence that identified hazards are addressed promptly and risks minimised. A current hazard register is available.</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>	<p>PA Low</p>	<p>The quality and risk management plan provide guidelines and processes for events requiring essential notification reporting for example; health and safety; police investigations; and sudden death. The management team are aware of situations which require the facility to report and notify statutory authorities. Interviews confirmed that these would be reported to the appropriate authority via the UCG national support office. Interview confirmed that the appointment of the clinical services manager in November 2018 had been notified to HealthCERT. There had been no other events requiring an essential notification.</p> <p>A review of orientation records demonstrated that staff receive education at orientation on the incident/accident reporting process. Staff interviews confirmed an understanding of the adverse</p>

		<p>event reporting process and their obligation to document all untoward events.</p> <p>There is an implemented incident/accident reporting process and incident/accident reporting forms are available on the staff notice board. Interviews with staff and review of documentation evidenced that staff document adverse, unplanned or untoward events on an incident/accident form which is entered onto an electronic data base and signed off by the facility manager or CSM.</p> <p>Incident/accident reports selected for review evidenced that an assessment had been conducted. However, observations were not consistently completed for residents following an unwitnessed fall. There is evidence of notification of the resident's nominated next of kin where appropriate and a corresponding note in the resident's progress notes.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position are documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include reference checks; a signed employment agreement; position specific job description; police vetting; and referee checking. An appraisal schedule is in place and staff files reviewed evidenced a current performance appraisal.</p> <p>There are systems in place to record and track such things as training, competencies and currency of annual practising certificates and practitioners' certificates. Current certificates were evidenced for all staff that require them including: RNs; general practitioners (GPs); nurse practitioner; physiotherapist; podiatrist; pharmacists; and dietitian.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency on a number of tasks, including hand hygiene; hoist use; and personal cares. Interviews confirmed that new staff are supported and buddied over their orientation into their new roles.</p> <p>The organisation has implemented the UCG documented role specific core annual education and training modules. Education session attendance records evidenced that ongoing education is provided, appropriate to all levels of resident care. There are systems in place to ensure that staff maintain current competencies. There is at least one caregiver on each shift who has current medication competencies. Training records and interviews confirmed that staff have undertaken a minimum of eight hours of relevant training.</p> <p>Eight of eight RNs, including the clinical services manager have completed interRAI assessments training and competencies.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented staff duty roster allocation process in place to ensure optimal cover with appropriately skilled, educated and qualified staff.</p> <p>Rosters are made available to staff two weeks in advance. The roster is reviewed on a weekly basis in conjunction with safe rostering tools and occupancy or as required and staffing levels altered to accommodate changes in residents' needs and acuity.</p> <p>There are sufficient RNs and caregivers available to safely maintain the rosters for the provision of care, to accommodate increases in workloads and acuity of residents. The facility includes a rest home wing and hospital wing with a central nurses' station. In addition to the CSM, who is on duty on the morning from Monday to Friday, there is a RN on duty on the day shift covering 7 am to 7pm, seven days per week, plus an additional RN on Tuesday's to cover the general practitioner visits. There is one RN on the evening night shift covering 7 pm to 7 am.</p> <p>There are five caregivers on each morning shift (including three short shifts) in the hospital wing, and one in the rest home wing. On the afternoon shift there are four caregivers in the hospital wing (including three short shifts) and one caregiver in the rest home wing. On night shift there are three caregivers for the facility. Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy and the requirements of the contract.</p> <p>There are 37 staff, including: the management team; administration; clinical staff; activities co-ordinator; mobility co-ordinator; maintenance; and household staff. Household staff include laundry assistants and kitchen staff who provide services seven day a week and cleaning staff who provide services six days per week. The facility manager and CSM or an RN, are on call after hours.</p> <p>Observation of service delivery confirmed that residents' needs were being met in a timely manner. Resident and family interviews stated that staffing is adequate to meet the needs of residents. Staff confirmed that they can complete their scheduled tasks and resident cares over their shift.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Residents' records are maintained in hardcopy with electronic medication charts in use. Residents' information, including progress notes, are legible and entered into the resident's record in an accurate and timely manner, identifying the name and designation of the person making the entry. Residents' progress notes are completed every shift, detailing resident response to service provision.</p> <p>There are policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff interviews confirmed an awareness of their obligations and the procedures for maintaining confidentiality of resident information. Resident care and support information can be accessed in a timely manner and when not in use is protected from unauthorised access by being</p>

		<p>in a locked cupboard in the nurses' station. Archived records are stored securely and are retrievable if required. Documentation containing sensitive resident information is not displayed in a way that could be viewed by unauthorised persons.</p> <p>Each resident's information is maintained in an individual, uniquely identifiable record. Records include information obtained on admission, with input from the resident's family and resident where applicable.</p> <p>The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. Electronic medication charts are kept separate from residents' files and are accessible by authorised personnel only.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents' entry processes into the service are recorded and implemented. Needs assessments are completed for rest home and hospital level of care, including YPDs. The organisational information pack is available for residents and their family. The admission agreement defines the scope of the service, includes all contractual requirements and evidenced resident and/or family sign off.</p> <p>Interviews with residents and family, and review of records, confirmed the admission process was completed by appropriately trained staff (refer to 1.3.3.3).</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge and transfer is managed in a planned and coordinated manner. There is open communication between services, the resident and the family. At the time of transition appropriate information is provided to the service or to the individual responsible for the ongoing management of the resident. Referrals are documented in the residents' progress notes.</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>	FA	<p>The medication area evidenced an appropriate and secure medicine dispensing system.</p> <p>Each stage of medication management is recorded in detail and communicated to residents and their families in a way that complies with legislation and guidelines. The medicines storage area is free from heat, moisture and light, with medicines stored in original dispensed packs. Weekly checks are in place. There is evidence of six-monthly physical stocktakes by the pharmacy. The medication fridge temperatures are completed and recorded daily.</p> <p>All staff authorised to administer medicines have current competencies and education in medicine management is provided. Electronic medicine charts reviewed, evidenced current residents' photo</p>

		<p>identification, legibility, as required (PRN) medication charted according to prescribing requirements, three monthly medicine reviews and discontinued medicines documented as required. The clinical services manager confirmed that the facility is not storing any vaccines. Vaccines are provided and stored by a third party who is authorised and trained to do so.</p> <p>Residents' medicine charts record all medications. The service facilitates self-administration of medicines for young people with disabilities and other residents who can do so in accordance with policies and procedures. At the time of the audit there were four residents self-administering medicines and all have completed current competency testing. Competency testing for residents self-administering medicines occurs at the three-monthly medical review.</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>	FA	<p>The cook oversees food provision at UCG Manurewa. They are supported by a weekend cook and a kitchen assistant. All kitchen staff have safe food handling qualification and had completed relevant food handling training. The food, fluid and nutritional requirements of the residents are provided in line with recognised nutritional guidelines for older people and for those with other nutritional needs under contracts held by the facility (e.g. YPD). The menu has been reviewed by a dietitian. A current food control plan last verified in August 2019 has been implemented. Food procurement; production; preparation; storage; transportation; delivery and disposal comply with current legislation and guidelines.</p> <p>Residents' dietary profiles are completed by a RN on admission, identifying the residents' dietary requirements and preferences. There were current copies of the residents' dietary profiles located in the kitchen. Special equipment to meet residents' nutritional needs and disabilities, was sighted. There are staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p> <p>Residents and families interviewed confirmed satisfaction with the food service.</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 appropriate.</p>	FA	<p>There is a process in place to inform residents and family of the reasons why services are declined, should this occur.</p> <p>When residents are declined access to the service; residents and their family, the referral agency and/or the GP, are informed of the decline to entry. The residents are declined entry if not within the scope of the service or if a bed is not available and discussions with relevant services are held to provide alternative options.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Residents' needs, outcomes and goals are identified through the assessment process (refer to 1.3.3.3). Assessments are recorded, reflecting data from a range of sources, including the resident; family; GP; specialist and the referrer. Policies and protocols are in place to ensure continuity of service delivery.</p> <p>The service has appropriate resources and equipment. The assessments are conducted in a safe and appropriate environment, usually in the resident's room. Interviews with residents and family confirmed their involvement in the assessments, care planning, review, treatment and evaluation of care.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Residents' care plans are individualised, integrated and up to date (refer to 1.3.3.3). Recorded interventions reflect the risk assessments and the level of care required. InterRAI assessments are completed by RNs and inform the person-centred care plans (refer to 1.3.3.3). The short term care plans are developed for the management of acute problems, when required, and signed off by the RN when problems are resolved. Interviews with residents confirmed they have input into their care planning and review.</p> <p>Individual health and wellbeing plans for YPDs support plans are person centred, developed with the person and includes evidence of community participation, meeting physical and health needs.</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 residents' care plans evidence interventions based on assessed needs, desired outcomes or goals of the residents (refer to 1.3.3.3). The GP documentation and records are current. Interviews with residents and families confirmed their and their relatives' care and treatments meet their needs. Staff interviews confirmed they are familiar with the needs of the residents they are allocated to. Family communication is recorded in the residents' files.</p> <p>Resident and family interviews confirmed residents have access to services in the community and are supported to maintain these links. Nursing progress notes and observation charts are maintained.</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</p>	<p>FA</p>	<p>Interviews with the activities coordinator (AC) confirmed the activities programme meets the needs of the service groups. The AC plans, implements and evaluates the activities programme. There is one activity programme for the rest home and hospital residents and all YPDs have specific activities individually designed to facilitate more social interaction with others.</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>Regular exercises and outings are provided for those residents able to participate. The activity programme includes input from external agencies, includes celebration of festive occasions and significant events and supports participation in ordinary unplanned/spontaneous activities. Young people with disabilities can participate in a range of education, recreation, leisure, cultural and community events according to their interests and preferences.</p> <p>There are current, individualised activities care plans in residents' files. The residents' activities attendance records are maintained. The residents' meeting minutes evidenced residents' involvement into the planned activities programme.</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>Resident care is evaluated on each shift and reported in the progress notes. Change in a resident's condition is noted and reported to the RN. Care plan evaluations and reassessments occur every six months or when the resident's condition changes (refer to 1.3.3.3).</p> <p>Short-term care plans are initiated for short-term concerns, such as: infections; wound care; changes in mobility and acute conditions. Short-term care plans are reviewed daily, weekly or fortnightly, as indicated by the degree of risk noted during the assessment process. The wound care plans evidence timely reviews.</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 providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The service has processes in place to provide opportunities for residents to choose when accessing or when being referred to other health and/or disability services. The family communication sheets, located in the residents' files, confirmed family involvement. The service has a multidisciplinary team approach. Progress notes and communication records confirm residents and their families are advised of their options to access other health and disability services.</p>
<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>	<p>FA</p>	<p>Documented policies and procedures for the management of waste and hazardous substances are in place. Policies and procedures specify safety requirements that comply with legislation, including the requirements for clear labelling and disposal of and collection of waste. The hazard register is accessible and current.</p> <p>Current material safety data sheets are available and accessible to staff in relevant places in the facility for example the sluice room and the cleaning cupboard. Staff receive training in the safe use of chemicals.</p>

		<p>Staff receive training and education in waste management and infection control as a component of the mandatory core training programme.</p> <p>Interviews and observations confirmed that there is enough personal protective clothing and equipment provided, such as: aprons; gloves and masks. Interviews confirmed that the use of personal protective clothing and equipment is appropriate to the recognised risks. Observation confirmed that personal protective clothing and equipment was used in high-risk areas.</p> <p>Staff interviews confirmed that there was clear delineation of duties and use of protective clothing for caregivers who assisted with laundry and meal services.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed in the entrance to the facility. Buildings, plant, and equipment comply with relevant legislation.</p> <p>A preventative and reactive maintenance schedule is implemented. Staff identify maintenance issues in a maintenance log book. These are reviewed by the maintenance person. A review of maintenance requests and interviews confirmed that repairs were conducted in a timely manner, typically within one to two days.</p> <p>Interviews with staff and visual inspection confirmed there is sufficient equipment available to support care. Interviews with YPD residents, by the consumer auditor confirmed that they have their own equipment and this is for their personal use only. The facility accommodates one YPD resident to have their own motor vehicle at the facility for this resident's personal use.</p> <p>The facility has an annual test and tag programme, and this is up to date. Evidence of checking and calibration of biomedical equipment was sighted. There is a system to ensure that the facility station wagon is routinely maintained. Inspection confirmed the vehicle has a current registration and warrant of fitness. Interviews reported that a commercial taxi company, with a van and hoist, is engaged to transport residents on outings.</p> <p>Hot water temperatures are assayed monthly and are maintained within recommended temperature ranges. A review of temperature assays and interview with the maintenance person confirmed that where hot water temperatures have been above the recommended safe temperature, action is taken, and rechecking of the temperature occurs to ensure a safe temperature is maintained.</p> <p>All resident areas can be accessed with mobility aides. Observation and interviews with family confirmed that residents can move freely around the facility. The external areas have outdoor seating and shade and can be accessed freely by residents and their visitors.</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 sufficient accessible toilets and showering facilities, of appropriate design to meet resident needs, are in each area of the facility. There is one rest home room with an ensuite toilet and the remaining rooms have access to shared toilet and bathroom facilities.</p> <p>Communal toilets have a system to indicate vacancy. Accessibility toilet facilities are available. There is a central visitors' toilet. All shower and toilet facilities have call bells; room to enable mobility aid use; approved handrails; and other equipment to facilitate ease of mobility and independence.</p> <p>Residents were observed being supported to access communal showers in a manner that was respectful and preserved the resident's dignity.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Residents have their own rooms, and each is of a size to allow residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. Interviews with residents and observation confirmed that there was enough space to accommodate: personal items; furniture; equipment and staff as required.</p> <p>Residents and their families can personalise the resident's room. Furniture in resident's rooms include resident's own personal pieces and memorabilia; is appropriate to the setting and is arranged in a manner that enables residents to mobilise freely.</p> <p>There are designated areas to safely store equipment such as: wheel chairs; walking frames; commodes and hoists.</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>There is a central dining room and an adjoining lounge as well as a smaller lounge closer to the hospital wing. All internal communal areas have seating and external views. There are areas within communal areas that are available for all residents to access for privacy if they wish. Observation and interviews with residents and family confirmed that residents can move freely around the facility and that the accommodation meets residents' needs.</p> <p>There are areas for storing activities equipment and resources. The lounge/dining area is used for activities.</p> <p>Residents were observed to have their meals with other residents in the communal dining rooms.</p>
<p>Standard 1.4.6: Cleaning And Laundry</p>	FA	<p>All laundry, including residents' personal clothing, is completed on site in the facility laundry. Colour</p>

<p>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>		<p>coded, covered laundry trolleys and bags were observed to be used for transport. A laundry assistant works six hours per day, six days per week. Interview with the laundry assistant confirmed knowledge of their role including management of any infectious linen. There is clear delineation and observation of clean and dirty areas in the laundry. Interviews of residents, family members and staff identified that the laundry standard met residents' needs. There were no concerns expressed about missing personal laundry.</p> <p>There are two cleaners on duty each day, Monday through to Saturday, providing eight hours per day of cleaning with one cleaner on Sundays, providing five hours of cleaning. Cleaning duties and procedures are documented to ensure cleaning processes occur as expected. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. The cleaner stores chemicals on a trolley when cleaning an interview and observation confirmed awareness of the need to keep the trolley with them at all times. Staff receive training in the appropriate use of cleaning products.</p> <p>There is a sluice room adjacent to the laundry available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility.</p> <p>The effectiveness of cleaning and laundry processes are monitored through the internal audit process with no significant problems identified. Resident and family interviews, resident surveys and observation noted the facility to be clean and tidy.</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>	<p>FA</p>	<p>Staff files and training records demonstrated that orientation and annual training includes emergency and disaster procedures as well as fire safety. Emergency planning includes consideration of all residents. An approved fire evacuation plan is in place. Interviews with staff and review of documentation confirmed that fire drills are conducted at least six monthly. There is a sprinkler system installed throughout the facility and exit signage displayed. Training records confirm that staff have undertaken fire training.</p> <p>The staff competency register evidenced that staff have current first aid certificates. There is at least one staff member on each shift with a current first aid certificate.</p> <p>The facility has enough supplies to sustain staff and residents in an emergency. Alternative energy and utility sources are available in the event of the main supplies failing. These include: a gas barbeque; emergency lighting; and enough food, water, and continence supplies. The service's emergency plan includes considerations of all levels of resident need.</p> <p>Call bells are available to summon assistance in all resident rooms and bathrooms. Call bells are checked monthly by the maintenance person. Observation and family interviews confirmed that call</p>

		<p>bells are answered promptly.</p> <p>Security systems are in place to ensure the protection and safety of residents, visitors and staff. These include visitors signing in and out of the building and the facility being locked in the evenings with restricted entry, through ringing a call bell at the front entrance after hours. Staff receive training in security as part of the annual training programme.</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 accessed by residents have safe ventilation and at least one external window providing natural light. The facility is heated by a combination of gas and heat pump ceiling vented heating. Some heating units had recently been upgraded. The environment in all areas was noted to be maintained at a satisfactory temperature for residents.</p> <p>Systems are in place to obtain feedback on the comfort and temperature of the environment. Observation and interviews with residents and families confirmed that the environment was maintained at a comfortable temperature and there were no issues identified with the temperature of the facility.</p> <p>The facility has a designated external smoking area. At the time of the audit there were two residents who smoked.</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 prevention and control policies and procedures manual provides information and resources to inform staff on infection prevention and control. Strategies are in place to prevent exposure of infections to others. The responsibility for infection control is clearly defined in the infection prevention and control policy, including the responsibilities of the infection control committee, infection control nurse and the infection control team.</p> <p>There is a signed infection control nurse job description outlining responsibilities of the position. The infection control nurse is supported in their role by the facility manager, the clinical and quality advisor and the infection control team. The infection control nurse is the clinical services manager.</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</p>	FA	<p>The infection control nurse has access to relevant and current information, appropriate to the size and complexity of this service. Infection control is an agenda item at the facility's staff meetings, evidenced during review of meeting minutes and interviews with staff. The internal audit programme includes infection control audits to monitor the implementation of the infection control programme.</p>

programme and meet the needs of the organisation.		
<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>	FA	<p>The infection control policies and procedures are relevant to the service and reflect current accepted good practice and relevant legislative requirements. Policies are accessible to all personnel.</p> <p>The infection control policies and procedures are developed and reviewed regularly in consultation with input from relevant staff and external specialists. Infection control policies and procedures identify links to other documentation in the facility.</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>	FA	<p>Infection control education is provided to all staff. Infection control is included in staff orientation and education occurs as part of the ongoing in-service education programme. Interviews with staff advised that clinical staff identify situations where infection control education is required for a resident, including hand hygiene and cough etiquette.</p> <p>The CSM completed additional training for the role as the infection control nurse. The infection control staff education is provided by the infection control nurse, RNs and external specialists. Education sessions have evidence of staff attendance/participation and content of the presentations. Staff are required to complete infection control competencies, sighted in staff files and confirmed at staff interviews.</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>	FA	<p>The infection control nurse is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at staff meetings. The type of surveillance undertaken is appropriate to the size and complexity of the service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained. Residents' files evidenced the residents' who were diagnosed with an infection had a short-term care plan in place.</p> <p>In interviews, staff reported they are made aware of any infections through verbal handovers; short-term care plans; progress notes and communication with RNs and the CSM. There have been no outbreaks since the previous audit.</p> <p>The facility's surveillance data is benchmarked against other UCG facilities and this information is</p>

		shared with staff and management.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>The restraint and enabler definitions are congruent with the definitions in the standard. Assessment of residents, care planning, monitoring and evaluation of restraint and enabler use is recorded and implemented. There were two residents at the facility using restraints and two using enablers on audit days. The restraint and enabler use was documented in residents' care plans.</p> <p>Enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety confirmed by residents, family and staff. Enabler usage and prevention and/or de-escalation education and training is provided. Staff records evidenced restraint minimisation and safe practice training.</p>
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	<p>Legislation and requirements for restraint, inclusive of definitions and safe and appropriate guidelines for management of the use of restraint, is documented. The processes implemented reflect safe use of restraint. Restraint approval is completed with the RN, the GP and the restraint coordinator. Restraint assessment authorisation and plans are completed by the RN. The requirements for the use of the restraint are explained to the resident/family/whānau.</p> <p>Evaluation is undertaken to measure the effectiveness of restraint use and completed three-monthly. The resident/family/whānau are involved in the evaluation process. Staff confirmed their understanding of the use of restraint. The long term care plans identify restraint goals, interventions and outcomes.</p> <p>Education is provided to all staff in the form of workshops and covers alternatives to restraint use as well as the management processes for restraint minimisation and safe practice.</p>
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service records culturally safe practices; identification of desired outcomes; and possible alternatives to restraint. Restraint risks and monitoring timeframes are identified in the restraint assessment records.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint coordinator utilises other means to minimise risk, for example, the use of sensor mats prior to implementation of restraint. Restraint consents are signed by the GP, family and the

		restraint coordinator. The GP confirmed that the facility uses restraint safely.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint coordinator evaluates all episodes of restraint. Reviews include the effectiveness of the restraint in use, restraint-related injuries and whether the restraint is still required. The family are involved in the evaluation of the restraints' effectiveness and reviews. Documentation was sighted in the progress notes regarding restraint related matters. Restraint minimisation and safe practices are reviewed by the restraint committee at three monthly intervals.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Three monthly monitoring and annual quality reviews are conducted relating to the use of restraint/enablers. Restraint committee meetings are held monthly. Senior staff and RNs attend. The restraint coordinator reports to management monthly. Quality review findings and any recommendations are used to improve service provision and resident safety. The restraint minimisation policies are current and are available to guide staff.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>There is a policy for staff to follow that details the requirements for neurological observations for residents who have sustained an unwitnessed fall. Resident files demonstrate that observations including neurological observation are completed and documented. However, a review of five adverse events relating to unwitnessed falls evidenced that these five events did not evidence that neurological observations had been conducted.</p>	<p>Neurological observations are not consistently completed as required following a resident unwitnessed fall.</p>	<p>Ensure that neurological observations are completed of residents who have sustained unwitnessed falls.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely</p>	PA Low	<p>Admission agreements, initial assessments/care plans, interRAI assessments, short-term care plans and long term care plans are completed. These were not always completed or able to be verified as completed, within the required timeframes.</p> <p>Eight resident files were reviewed, including five young people with disabilities. Three of the residents' files did</p>	<p>Not all required timeframes are met, or able to be verified, for initial assessments/care plans, interRAI assessments,</p>	<p>Ensure all required timeframes are met, or able to be verified, for initial assessments/care plans, interRAI assessments, completion and updates of long- term care plans and</p>

<p>meet the needs of the consumer.</p>		<p>not evidence the initial assessments or the initial care plans and as a result the required timeframes for implementation of initial care could not be verified for all three residents.</p> <p>Of the eight residents' files reviewed there were two residents' files where the admission agreements were not signed within the required timeframes.</p> <p>Two of the long-term care plans do not meet the required timeframes for implementation. One of the long-term care plans reviewed was completed prior to the interRAI assessment, with the interRAI assessment not meeting the required timeframes. Another long-term care plan was not updated after the interRAI assessment was completed. The long-term care plan that was not reviewed in a timely manner was updated during the audit, mitigating the risk for the resident.</p>	<p>completion and updates of long-term care plans and signing of admission agreements</p>	<p>signing of admission agreements do not consistently meet the required timeframes for implementation.</p> <p>90 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.