

The Ultimate Care Group Limited - Ultimate Care Karadean

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 Karadean	
Services audited:	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical	
Dates of audit:	Start date: 13 October 2020	End date: 14 October 2020
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:	46	



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Ultimate Care Karadean can provide care for up to 53 residents and is certified to provide rest home, hospital and residential disability services. There were 46 residents at the facility on the first day of the audit.

This certification audit was conducted against the Health and Disability Services Standards and the service contracts with the district health board.

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

Areas identified as requiring improvement relate to: management of quality and risk systems, including the development and implementation of corrective actions; neurological assessments post-falls; prompt response to call bells; interRAI assessments and care planning; preventative maintenance of the facility to ensure residents' safety; and infection control education.

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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Ultimate Care Karadean residents and families are informed of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights and rights to advocacy on admission and during ongoing service delivery.

Staff demonstrate an understanding of residents' rights and this knowledge is incorporated into the daily cares provided. Residents and families confirmed that residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence.

Residents have their needs met in a manner that respects their cultural values and beliefs, including residents who identify themselves as Māori.

Policies are in place to ensure residents are free from discrimination, abuse and neglect.

There are systems and processes in place to support an environment that is conducive to open communication between staff, residents and families. Informed consent is practised, and written consent is gained when required. The facility supports regular meetings between residents and advocates. Links with family and the community are encouraged and maintained, including for young people with disabilities.

There is a policy in place to manage complaints that conforms to the Code of Health and Disability Services Consumers' Rights and is implemented.

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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The organisation's mission statement and vision are documented and displayed in the facility. The service has current business plan and quality and risk management plan in place. The Ultimate Care Group executive team provides governance to the facility.

An experienced and suitably qualified roving manager ensured management of the facility until a new manager with both clinical leadership and management qualifications was appointed. A clinical services manager oversees the clinical and care services in the facility. A regional clinical lead and regional manager support the facility managers in their roles.

The quality and risk management systems include: internal audits; monitoring of clinical indicators; complaints management; resident satisfaction surveys; and incident/accident management.

The human resource policies are implemented in relation to recruitment and orientation. Staffing rosters meet contract requirements. Staff are allocated to support residents as per their individual needs.

Information management systems ensure secure management of resident and staff data.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents' entry into the service is managed with the required pre-admission assessments and the relevant information provided to the potential resident/family.

A registered nurse completes the initial nursing assessment of the resident on their admission to the facility. An initial medical assessment is conducted by the general practitioner within the required timeframe.

Residents' care plans are individualised and based on a comprehensive range of information triggered by interRAI assessments. Short-term care plans are documented for acute problems that arise.

Residents' clinical records, interview with staff, residents and family evidenced that care provided meets the needs of residents.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Residents' referrals to other external specialities occurs as required.

A medication management system is implemented to comply with legislation, protocols, and guidelines. Medicines are administered by staff who are deemed competent to do so. Residents who self-administer medicines do so according to policy and guidelines.

The food service operates under a current food control plan and meets the nutritional needs of the residents.

Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is a current building warrant of fitness. Waste and hazardous substances are managed safely. Staff use protective equipment and clothing where required.

Occupied resident areas are light, ventilated and maintained at a comfortable temperature.

Bedrooms, bathrooms and communal areas are of appropriate size to support the safe mobilisation of residents and the provision of cares. Several common spaces are available for residents' activities, social interactions, and private meetings. External gardens are accessible and offer shade and seating.

Three bedrooms are currently used for storage and would be refurbished if needed to be occupied.

Cleaning and on-site laundry services are provided seven days a week.

Security and emergency systems and equipment are in place with regular fire evacuation procedures completed.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service meets the requirements of this standard. There were no restraints or enablers in use during the audit.

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.		Some standards applicable to this service partially attained and of low risk.
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The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator is responsible for the collation and reporting of infections and orientation and education of staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control education within the facility. There has been one outbreak of norovirus in October 2019.

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	38	0	2	4	0	0
Criteria	0	85	0	3	5	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>Ultimate Care Karadean (UC Karadean) has policies, procedures and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Staff receive education on the Code at orientation that was verified in training records. Interviews with both clinical and non-clinical staff proved their understanding of the Code requirements in practice.</p> <p>Observed interactions between staff and residents evidenced services' provision and communication that was respectful of residents' dignity, individuality and informed choices.</p> <p>Chaplain interviewed confirmed that residents are supported to maintain their independence and to practice their personal values and beliefs.</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</p>	FA	<p>A consent policy is in place to ensure that a resident who is competent to consent to a treatment or procedure, has been given information to reach an independent decision. The policy includes a definition of consent and how this will be facilitated and obtained.</p> <p>Observations evidenced that residents or their EPOAs sign informed consents that include but</p>

<p>informed choices and give informed consent.</p>		<p>are not limited to outings, photographs, routine medical treatment, storage of medical records, and sharing of information in line with legislation.</p> <p>All staff interviewed, including non-clinical staff, demonstrated they are cognisant of the procedures to uphold informed consent.</p> <p>The registered nurses (RNs) confirmed they discuss informed consent with residents and family during admission and care planning. This includes consent for resuscitation and advance directives. Clinical records showed that the GP signs to confirm the competence of the resident to consent, and the resuscitation status decisions are documented and reviewed annually. When required, advance care planning, designated EPOA, and EPOA activation are documented.</p>
<p>Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>There was evidence through advocacy meeting minutes, interviews with management, family, residents and a chaplain, that the service promotes and facilitates the residents' access to external advocates and support people.</p> <p>Family corroborated they are included in the care planning process.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>There are no set visiting hours at UC Karadean. Family reported that under normal circumstances they can visit at any time. Residents confirmed they are supported and encouraged to access community services with visitors or as part of the planned activities programme. Residents were observed freely leaving the facility with accompanying visitors.</p> <p>Direct observations and interviews with YPDs provided examples of the facility giving YPDs the opportunity to carry out meaningful activities and to maintain their social links with the community.</p>
<p>Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisation has a complaint policy and process to ensure that the complaints' management aligns with Right 10 of the Code. The complaint process is explained to new residents on admission and includes provision of supporting documentation. Complaint forms were seen to be available in the facility foyer as well as a labelled, secure complaint box, and a flow chart explaining the process to follow to make a complaint.</p> <p>Review of complaint forms and register verified that complaints were processed timely and as per policy, including verbal complaints. Written responses, investigations and corrective actions</p>

		<p>were issued in response to complaints, with evidence of implemented improvements/problem resolution.</p> <p>A complaints' register was maintained.</p> <p>The roving FM and regional manager stated that no complaints have been received from external agencies since the last audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information on the Code and Nationwide Health and Disability Advocacy Services is available and displayed in English and te reo Māori throughout the facility. The clinical services manager (CSM) explains information provided to residents and families pre-admission, which includes information on the Code, advocacy and the complaints process. Each resident is allocated a primary nurse who reviews those rights with the resident and family, upon entry to the service.</p> <p>Residents interviewed confirmed they understand their rights and access to an advocate if needed.</p> <p>The facility supports the organisation of quarterly meetings by an external advocate with the residents and their families, as evidenced by the meetings' schedule and minutes of meetings.</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>The service has a philosophy that promotes dignity, respect and quality of life for the residents. Interviews with all categories of staff evidenced they endorse those values and provided examples of how young people with disabilities (YPD) are supported to maintain their independence and expression of personal identity.</p> <p>Existing policies and procedures conform to the requirements of the Privacy Act and Health and Information Privacy Code in relation to residents' privacy. Staff interviewed described the procedures for maintaining confidentiality of residents' information. Staff were observed to knock on bedroom doors prior to entry, and door signs could be placed to indicate a resident's wish for privacy.</p> <p>Residents were observed to be groomed in a manner that respected their individuality. There was access to an on-site hairdresser once a week.</p> <p>Initial and ongoing assessments to ascertain details of residents' beliefs and values are completed and documented in clinical files. Interventions to support these are identified and evaluated. Staff interviewed were aware of residents' individual preferences and provided examples of facilitating favourite activities.</p>

		Staff have completed education around abuse and neglect and could describe the reporting process should any be identified. Family, staff, residents and the general practitioner (GP) stated that there was no evidence of abuse and neglect.
<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>Ultimate Care Group (UCG) has a Māori health plan that identifies culturally sensitive responses to Māori beliefs and to Māori residents' needs in relation to illness. Staff receive training in cultural safety as part of the set UCG education programme for all service providers. The cultural needs of residents and their whānau are documented in mandatory admission assessments.</p> <p>There was one resident who identified as Māori.</p> <p>Interview with the CSM evidenced they were cognisant of the individual needs of the Māori resident and their whānau; they knew where to access spiritual and cultural advocacy and support in the community; and this was reflected in the care provided.</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>An interview was conducted with the chaplain who visits the residents in the facility once a week, and provides room blessings when required. The chaplain described how the facility facilitates residents' access to spiritual and cultural support.</p> <p>There is a non-sectarian church service notified on the activities' programme available to residents.</p> <p>Residents' meeting minutes indicated residents' participation in review and planning of activities offered by the facility depending on their cultural and social preferences.</p> <p>Values and beliefs of specific residents were discussed by clinical staff who gave examples of accommodating care to support those.</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>The facility adheres to UCG policies and processes to ensure that residents are free from discrimination, coercion, harassment, and financial exploitation.</p> <p>Staff signed agreements defining the standards of conduct as part of their employment documentation.</p> <p>Interviews with staff verified they are aware of professional boundaries and obligation to report actual or suspected misconduct. Staff voiced they would not hesitate to report such incidents if</p>

		<p>they would occur.</p> <p>Interviews with residents, families, and external providers confirmed that staff acted professionally and that there was no evidence of misconduct.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The organisation has an open disclosure policy that promotes a transparent, consistent approach to full and open disclosure where there is a harmful event during the course of resident care or a change in resident's condition. Completed accident/incident forms, clinical records and resident and family interviews demonstrated that open disclosure is implemented and enduring power of attorneys (EPOAs) and next of kin are informed when required.</p> <p>Meeting minutes and interviews with residents and family established that they are encouraged to participate in residents and families' meetings and discussions to provide feedback. An annual residents' satisfaction survey is sent via email or provided in person, to collect satisfaction information that is recorded (refer to 1.2.3.8). There are documented initiatives to improve communication with residents, for example a trial of communication books to capture feedback on meals at the time of dining (refer to 1.2.3.6)</p> <p>There were no residents who required the services of an interpreter. The process to access interpretation support services was described by the CSM should the need arise.</p> <p>Examples of adaptive communication with residents with physical and intellectual disabilities were provided by the CSM, which included but not limited to: encouragement to verbalise needs and symptoms; supply of information for reassurance and independence; use of verbal cues; and involvement of family members in communication.</p> <p>The three YPDs were described by care giving staff to be able to communicate and to express their needs.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The UC Karadean facility is part of UCG with the executive team providing direction to the service. The current roving FM reports to a regional manager who oversees the facility's quality and operational performance. The regional clinical lead supports the clinical operations at the facility. The UCG director of nursing and wellness supervises clinical governance and management nationally for each facility. The regional manager provided support to the facility at the time of audit.</p> <p>The organisation has a vision, mission and values in place with the residents at its core. The organisation values were displayed in UC Karadean pamphlets in the foyer of the facility and</p>

		<p>are advertised through the organisation's website.</p> <p>On the day of audit, the FM position was vacant and a permanent nurse manager role, with both clinical leadership and management qualifications, was being advertised. A UCG roving manager with 14 years' experience in clinical management ensured the management of the facility. This was for a week duration until a new interim roving FM was in place. The UCG roving FM arranged in the interim has a long-term aged care management experience as a clinical nurse manager and management experience as a FM for UCG. A CSM has been in their position for over a year and has experience with UCG as a RN prior to this position. The current roving FM is also a roving clinical manager with nursing education qualification who has provided mentorship to the facility CSM since they started in their role.</p> <p>The service provides hospital, rest home, and residential disability care – physical and intellectual, for up to 53 residents. All beds are dual purpose. There are no occupational right agreements (ORAs) available.</p> <p>At the time of the audit, there were a total of 46 residents in the service: 17 receiving rest home care and 29 receiving hospital level care. Two YPDs were assessed at hospital service level, and one YPD at rest home service level.</p> <p>Sighted district health board (DHB) contracts also included aged residential care (ARC) agreements for respite, support care, and day care.</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>	<p>FA</p>	<p>The regional manager and current roving FM confirmed that UCG national support office would dispatch roving managers to cover prolonged absences from either the FM or the CSM at the facility. In the case of a short absence from the FM, the CSM can operate with the regional manager assistance. In the short absence of the CSM, a manager from another regional facility can provide cover, and the newly appointed FM who holds a RN practicing certificate will be able to undertake CSM duties temporarily.</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</p>	<p>PA Moderate</p>	<p>The facility follows UCG's annual quality and risk management plan which incorporates the statutory and regulatory requirements against relevant standards and was sighted to be current. The plan supports continuous quality improvement through reporting on mandatory service indicators and yearly quality projects. The plan encourages: incidents reporting; risk assessment; escalation and resolution; and prescribes the terms of reference for facility quality meetings.</p> <p>The facility adheres to UCG organisation-wide policies and procedures that follow current best</p>

<p>principles.</p>		<p>practice and legislation requirements. However, the documented facility hardcopy manual was not up to date.</p> <p>Review of meeting minutes demonstrated that facility meetings are implemented as per schedule and cover: quality; health and safety; residents and families' meetings; staff meetings; and special committees on infection control and restraint.</p> <p>There is an existing system to capture the components of service delivery through: sighted electronic reports on clinical indicators; internal audits; staffing and training levels; residents' satisfaction surveys; registration of hazards and safety risks; accidents/incidents; and complaints.</p> <p>Observations evidenced that a current hazard register and health and safety declaration forms are completed and acknowledge ongoing and emerging health and safety risks. Staff receive health and safety training as part of their recorded orientation. Health and safety meetings are held with representatives from various categories of staff who were interviewed. All risks registered have an associated rating and are reviewed annually.</p> <p>However, documentation and interviews evidenced that the systems and processes of quality data reporting; evaluation; communication of outcomes to staff; and corrective action plans were not always fully completed.</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>Managers interviewed demonstrated they are aware of their responsibilities in relation to essential notification and incident reporting.</p> <p>Notifications to HealthCERT under Section 31 were noted for the appointment of the new CSM and for two pressure injuries that included deep and unstageable pressure wounds. The regional manager stated that the notification of the current change of FM was being processed. Notification of a norovirus outbreak in October 2019 to Public Health and to the DHB was sighted.</p> <p>Documentation review and interviews identified a process for the reporting of adverse events with the aim to inform the risk management and quality improvement systems (refer to 1.2.3.6). A sample of recorded incidents/accidents evidenced they were predominantly falls with or without injury. Other reported events included but were not limited to: skin tears; bruises; and challenging behaviours.</p> <p>Sampled events are reviewed by the CSM who rates their risk, updates the electronic event reporting system, and indicates an individual corrective action for each event (refer 1.2.3.8). However, responses to unwitnessed falls did not always evidence best practice.</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 resources management follows a process which adheres to the principles of good employment practice and the Employment Relations Act 2000. This process was observed through the review of staff files and involves: referee checks; police vetting; and a signed employment contract against a job description. Sampled staff files evidenced that newly employed staff have a three-month review and all staff appraisals were current within the year.</p> <p>The CSM is the infection prevention and control and restraint coordinator for the facility and has received specific job descriptions for these roles (refer to 3.4.1).</p> <p>All employed nurses have a current annual practicing certificate on record. Other practicing certificates were verified for: the podiatrist; physiotherapist; dietitian; pharmacists; and the GP. There was a qualified diversional therapist (DT) who directs two activities assistants. The DT who provides car driving services to the residents and takes them on social outings in the van has a driving licence on file. Non-clinical staff include household and laundry personnel, a maintenance person, a part-time gardener, and kitchen staff.</p> <p>There is documented evidence that staff complete an induction process and are orientated to core competencies. The roving FM demonstrated the use of an electronic annual education calendar to plan and record continuous staff professional development that is relevant to the needs of residents. Listed education sessions are provided through online, on-site, and off-site training and include topics relevant to YPDs. Community clinical nurse specialist spoke about the education sessions they regularly provide to clinical staff and satisfaction with level of attendance.</p> <p>The roving FM interviewed supports the CSM to provide preceptorship to three newly appointed RNs in the facility.</p> <p>Three out of five RNs are interRAI trained and one of two enrolled nurses (ENs) are interRAI trained. Two ENs and three care givers (CG) with level four qualification worked in the facility.</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>The CSM is responsible for the rostering of clinical staff, while the roving FM is responsible for rostering non-clinical personnel.</p> <p>The CSM discussed the clinical roster model which was based on the occupancy in the facility; the level of acuity; the allocation of staff according to skill mixes; and the daily workload. For example, there was one agency RN working exclusively in the facility during COVID-19 lockdown to support staffing levels. There are additional planned EN duties on Thursday and Friday afternoons to assist the implementation of changes to residents' care plans after the GP</p>

		<p>rounds on those days.</p> <p>Monday to Sunday clinical service involves: one RN at all times during the day and night; support from one EN in the morning; assistance from six CGs in the morning, five in the afternoon and two at night. The RN is based in the nursing station which is the most central to the facility and where residents with complex cares are preferably placed. The second nursing station is part of an area where residents' needs are less acute and is staffed with at least one EN or one senior CG.</p> <p>A sample of rosters established that RN cover is ensured 24/7 and unplanned staff absences are filled in by casual and current staff, and exceptionally agency staff (refer to 1.3.3.3).</p> <p>A podiatrist and physiotherapist are available on demand. The activities staff provide activities five days a week.</p> <p>The roving FM, CSM and regional manager are on call 24/7 to support the facility with emergency matters.</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>Observations of the facility nursing stations and offices verified that residents' clinical files are stored securely.</p> <p>Electronic information has secured password access and is protected from the view of the public.</p> <p>Review of documentation established that entries were legible, dated and signed by the relevant CG, RN or other staff members, and included their designation. Approved abbreviations are listed. Resident information is recorded with details and in a timely manner and demonstrated documentation of continuous service provision with the involvement of nursing, medical, allied health, and community support teams.</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>	<p>FA</p>	<p>The service has an admission policy to guide a resident's admission pathway. Management assess all potential residents prior to entry to the service, confirmed at interviews. The prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with a written information pack about the service and the admission process. All prospective residents are required to have had a needs assessment and service coordination (NASC) assessment to establish the appropriate level of care required. All residents' files reviewed contained a signed and dated admission agreement that aligned with the requirements of the ARC contract.</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>If the needs of a resident change and they are no longer suitable for the services offered at UC Karadean, a referral for reassessment to NASC team is actioned, and a new placement is found, in consultation with the resident and whānau/family. Residents who require emergency admissions to hospital are managed appropriately and relevant information is provided in written format to the emergency department. The facility uses the transfer from (yellow) aged care to hospital transfer envelope. Family are notified if a resident is to be transferred.</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 facility uses an electronic prescribing system and a medication blister pack system. Medications are checked on arrival to the facility by RNs and safely stored. All medications sighted were within current use by dates. A supply of relevant stock medication is held, for the administration to hospital residents when needed for acute/semi acute conditions outside of normal business hours. There are no vaccines stored on site and there are no standing orders used at the service.</p> <p>A medication round was observed and staff demonstrated knowledge and understanding of their role and responsibility related to each stage of medicine management and administration. All staff interviewed confirmed that they had received medication management education and have current competencies in medication management.</p> <p>Residents who are deemed to be competent may self-administer medicines and do so according to policy.</p> <p>The electronic prescribing programme evidenced that all resident photos were current with a true likeness of the resident. Medication records reviewed confirmed medications were reviewed three-monthly by the GP.</p> <p>The medication fridge temperature was checked daily and a procedure is in place to guide staff actions in the event of fridge temperature failure, however, there is no evidence that the medication room temperature is monitored (refer to 1.4.2.4).</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</p>	FA	<p>The food service is managed on site by a kitchen manager who works four days per week. The manager is supported by two cooks and two kitchen hands. All kitchen staff hold a food safety certificate. The menu follows summer and winter patterns, on a four-weekly rotation. The menu has been reviewed by a registered dietitian within the last twelve months.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and</p>

<p>delivery.</p>		<p>disposal comply with current legislation and guidelines. The service operates with an approved food safety plan registration. Food temperatures are monitored and recorded, as well as fridge and freezer temperatures. All food stored was observed to have opened dates on the sealed container. Evidence was sighted of food rotation. The area was noted to be clean with a separate area for food preparation.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. This is reviewed six-monthly as part of the care plan review. Special equipment, to meet residents' needs, is available.</p> <p>The kitchen manager and a kitchen hand were interviewed and were able to discuss how they record residents' individual choices and requirements and how they meet those needs/requirements.</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>	<p>FA</p>	<p>The process for declining a prospective resident is addressed in the admission policy and implemented if required. If a resident's referral is received and the facility has no vacancy, or the potential resident's needs are unable to be met by the service, the local NASC service is advised, as is the resident and family members to ensure the prospective resident and family are supported to find an appropriate care alternative. A record is maintained of prospective residents who are declined entry.</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>In the sample of clinical files reviewed, residents were admitted to the facility following a recently completed interRAI needs assessment. Initial assessments on admission were made using information gathered from: discharge summaries; home care assessments; and from discussions with the resident and their relative where appropriate. Multiple assessment tools, including but not limited to: continence; skin; falls; pain assessments were used. These contributed to an initial assessment.</p> <p>InterRAI assessments were not always completed within the required 21 days of admission (refer to 1.3.3.3). Six-monthly interRAI reassessments were not always completed according within the six month timeframes (refer to 1.3.8.2).</p>
<p>Standard 1.3.5: Planning</p>	<p>FA</p>	<p>The care plans reviewed documented the required support to meet the needs of individual</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>residents as identified by the interRAI assessments (refer to 1.3.3.3). The clinical records demonstrated service integration: with progress notes; activities notes; medical and allied health professionals' assessments; and interventions documented. Any change in residents' care requirements were documented and communicated to relevant staff, as was observed on audit days. Residents and family members reported participation in the development and ongoing evaluation of the care plan.</p> <p>The review of care plans for YPDs evidenced: care plans were person centred; developed with the person; and included community participation, meeting their physical needs and their health needs.</p> <p>Evidence was sighted that the short-term care plans were developed in response to residents' acute health care problems. The short-term care plans were signed off by RNs when treatment was complete, and the problem had resolved. Clinical staff interviews described the appropriate use of short-term care plans and confirmed their involvement in the development of the plan and in delivering the interventions documented within the short-term care plan.</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>Review of the wounds at the facility evidenced the wound assessments, treatment and evaluations were in place for all current wounds. Evidence was sighted confirming the involvement of a wound care nurse specialist providing recommended treatments for some wounds.</p> <p>All residents' files reviewed had documented monthly observations and weight. In all residents' files reviewed the residents had maintained stable parameters. The CSM was able to articulate the pathway for a resident in a scenario when the monthly observations were unstable.</p> <p>Observation during the audit confirmed that adequate dressing and continence supplies are available on site, this was confirmed by staff during interviews.</p> <p>The GP was interviewed, and verified that medical input is sought in a timely manner and that medical directions are followed with satisfactory care provided.</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</p>	<p>FA</p>	<p>A DT is employed to plan and implement the activities programme at the facility. An activities assistant and the DT provide the activities programme that operates six days per week.</p> <p>The programme is planned monthly and residents receive a copy of planned monthly activities in their rooms. Monthly and daily activities plans were displayed on noticeboards around the facility.</p>

<p>service.</p>		<p>The activities programme for YPD residents is resident lead with input from the residents' significant others. The YPD residents also take part in the facility activities programme as desired. Volunteers from the local community are utilised to assist with the YPD residents.</p> <p>One-on-one time is spent with residents who choose to stay in rooms or are unable to participate in group activities. Outings are arranged.</p> <p>During the audit, residents and visitors were observed taking part in activities, and enjoying a musical entertainer, with many residents singing along with the entertainer.</p> <p>A social assessment and history is undertaken by the DT on the resident's admission to ascertain the resident's needs, interests, abilities and social requirements. This was confirmed in clinical files reviewed, which also evidenced attendance records, and entries by the DT of the resident's participation. Evaluation of the activities care plan is not always completed at the same time as the nursing care plan (refer to 1.3.8.2).</p> <p>Resident meetings provide an opportunity for residents to feedback on the programme. Residents and family interviewed expressed satisfaction with the 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>PA Moderate</p>	<p>When a resident's condition alters, the RN notifies the CSM who initiates a review and if required a GP consultation. Evidence was sighted in the clinical records that family members were notified of changes to their relative's health status, incidents and updates. Interviews with residents and family confirmed that their relative's needs are met, and they are kept informed of any health changes (refer to 1.3.3.3).</p> <p>In all clinical files reviewed there was regular documentation from CGs and a minimum of a daily entry by the RN which documented evaluation of the resident's health status and any changes observed. These changes are reported at the handover and short-term care plans developed if necessary.</p> <p>There was evidence of multidisciplinary team involvement in care plan reviews including, but not limited to: RN; allied health professionals; resident and family. The activities care plans were not always evaluated at the same time as the nursing care plans.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral</p>	<p>FA</p>	<p>Referrals to other external services were sighted in residents' files reviewed. There was evidence to confirm that the referrals were made with resident's consent and that the resident and family/whānau were kept informed of the referral process. Acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an</p>

<p>to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>ambulance if the circumstances dictate. During the audit a physiotherapist, and a palliative clinical nurse specialist were observed providing care to residents.</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>The facility adheres to UCG waste and hazardous management policies that conform to legislated requirements and embrace local council requirements. Policies include but are not limited to: considerations of staff orientation and education; incident/accident and hazards reporting; use of personnel protective equipment (PPE); and disposal of general, infectious and hazardous waste.</p> <p>Training records evidenced implementation of staff orientation and education on management of waste, infectious and hazardous substances. Staff interviewed, and observations confirmed handling of infectious and hazardous substances conformed to requirements. Waste was witnessed to be disposed in relevant coloured coded and recycling bags and bins.</p> <p>Supply and management of chemicals are contracted to external providers with chemical stocks and data sheets available in locked storage areas. Chemicals in use were identified to be labelled.</p> <p>During a tour of the facility, PPE was sighted to be available in areas where there were risks. On observation, staff were wearing relevant PPE during duties that involved a risk of exposure to hazardous substances or a risk of cross-contamination.</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>PA Moderate</p>	<p>A current building warrant of fitness is displayed at the entrance to the facility.</p> <p>The vehicles used for the transport of residents had current registration, warrant of fitness and first aid kits.</p> <p>Testing, tagging and calibration were completed and current for the sampled electrical, clinical and safety equipment.</p> <p>Records reviewed and interview with the maintenance person demonstrated that maintenance checks were performed, for example for lighting, fridges and room temperatures in all residential areas. However, there is no evidence of the medication room temperature being monitored.</p> <p>Hot water temperatures are documented for commercial services fixtures and for sanitary fixtures accessed by residents. However, safe temperatures are not maintained.</p> <p>Observation of the facility and interviews with staff confirmed equipment is available and</p>

		<p>adequately used to provide the necessary cares to residents, including the YPDs with physical disability. Examples of equipment include: pressure relieving devices; shower chairs; hoists and sensor alarm mats.</p> <p>The gardens are maintained by the maintenance person assisted by a gardener once a week. There are various outside areas with shades and renovated seating benches that can be accessed freely by residents and visitors. The corridors are wide to promote safe mobility, use of aids and independence.</p> <p>However, the service has no documented preventative maintenance schedule for the facility.</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 showers, hand basins and toilets throughout the facility to attend to personal hygiene, with a combination of ensembles, communal toilet/bathing facilities, toilets/baths shared between two rooms, and visitors' toilets (refer 1.4.2.4).</p> <p>All sighted residents' toilets and bathing areas have a call bell system; handrails; toileting and showering equipment to enhance and promote residents' independence.</p> <p>Privacy of shared facilities is ensured through vacant signs and locking systems. Residents were observed being supported to access communal toileting areas in ways that respected their 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>Observations verified there is adequate space in the occupied bedrooms to allow residents and staff to move freely, and to accommodate the use of mobility aids and equipment. Three certified rooms of a smaller size with no attached bathroom were currently used for storage, and can provide the space required for a resident, two staff members, and one equipment, for example a standing hoist, a wheelchair, or a comfort chair if needed.</p> <p>The residents' rooms observed are personalised with furnishings, photos and other personal possessions. Interviews with residents and staff confirmed that residents are supported to personalise their rooms, and that independent residents can bring their own beds if they prefer.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and</p>	FA	<p>The service has several lounges and dining areas sighted, including areas that can be used for entertainment and social activities. Managers reported that a combined dinner is organised once a fortnight to support residents gathering across the facility. A dedicated common area is organised for physical activities and contained exercise equipment and posters. One large room</p>

<p>accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>was converted into a whānau room available to residents and families for private use and social events. There are private spaces available to carry out activities or social meetings for YPDs.</p> <p>Furniture observed is appropriate to the setting and arranged in a manner that encourages residents' group interactions or individual relaxation. Care equipment is stored in dedicated spaces which are readily accessible for use.</p> <p>Communal areas were observed to be free of clutter and easily accessible to residents, staff and visitors. There is a designated parking space for mobility scooters.</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>	<p>FA</p>	<p>Laundry and cleaning services are provided seven days a week. Sampled rosters confirmed that cleaning and laundry duties are covered.</p> <p>The tour of the on-site laundry demonstrated the implementation of a clean/dirty process for the hygienic washing, drying and handling of personal clothes and commercial linen. Laundry machinery is maintained and had current tags. The safe and hygienic collection and transport of laundry items into relevant colour bags was witnessed. Household and laundry personnel interviewed demonstrated knowledge of the process to handle and wash infectious items when required.</p> <p>Residents clothing is labelled and personally delivered from the laundry, as observed. Residents and families confirmed satisfaction with laundry services in interviews and in satisfaction surveys.</p> <p>The facility was noticed to be clean and tidy. A documented cleaning schedule is in place. Household personnel interviewed are aware of the requirement to keep their cleaning trolleys in sight, which was confirmed through observation. Cleaning chemicals are managed through a closed system. Chemical bottles/cans in storage and in use were noted to be appropriately labelled.</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>A current evacuation plan was approved by the New Zealand Fire Service in 1999 with no change to the buildings since. The service has a documented evacuation and emergency plan. The last fire drill was completed in September 2020.</p> <p>All current staff have current fire and security training on record. Fire equipment sighted were tagged. Records for the last four months and interview with the maintenance person demonstrated mandatory safety checks are routinely performed for lighting, smoke and fire systems, and window latches (refer to 1.4.2.4).</p>

		<p>A documented civil defence plan is in place for the facility. There are adequate emergency supplies for the size of the organisation and the needs of the residents, which include the YPDs. Sighted stores in the event of a civil defence emergency include food; fresh water; blankets; emergency lighting; gas barbeques; and continence products. The regional manager explained that they attend a local community civil defence committee to prepare for emergencies. Ultimate Care Group holds an agreement with a regional contractor to supply a generator in case of power failure.</p> <p>Call bells are available to summon assistance in all residents' areas. Call bell systems are audited monthly to verify physical function by the maintenance person interviewed (1.4.2.4). The maintenance person and roving FM demonstrated a process to address faulty call bell systems in a timely manner if required. Interview described the electronic call bell system as automatically alerting the regional manager of unanswered calls bells after a prescribed time (refer to 1.3.3.3).</p> <p>All RNs and the DT hold a documented first aid certificate, as well as the maintenance person interviewed.</p> <p>The facility buildings are restricted from external access and secured after-hours.</p> <p>There is an emergency stock of PPE supplies observed to be stored on-site and also available from an UCG regional storage to cover urgent needs of infection control equipment during pandemics.</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>	<p>FA</p>	<p>On inspection, all residential areas in use were heated at a comfortable temperature. The regional manager stated that heating would be re-established in the three certified rooms currently used for storage if they were required for occupancy.</p> <p>Rooms and common living areas receive natural light and are ventilated. Each room has an external window that can open from inside for ventilation.</p> <p>The facility has a designated external smoking area for residents if needed. At the time of audit there were no 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</p>	<p>FA</p>	<p>There is an infection control programme that is developed by the infection control quality manager at organisational level and is appropriate for the size and complexity of the service. The responsibility for implementation and monitoring of the programme is the infection prevention control coordinator (IPCC), who is the CSM. A signed position description was</p>

<p>consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>sighted.</p> <p>The infection control audits are undertaken and communicated to the infection control quality manager at head office.</p> <p>Visitors are asked not to visit if they are unwell. Influenza vaccines are offered annually to residents and staff. Hand sanitisers and hand basins are available throughout the facility. Isolation trolleys are pre-stocked and on-site for use if required.</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>	<p>FA</p>	<p>The IPCC has access to additional information and support from the infection control quality manager at the organisation's head office, the local GP, and the infection prevention and control clinical nurse specialist at the DHB. Evidence was sighted to confirm that support has also been sought from the public health unit at the DHB. The IPCC has access to residents' clinical records and laboratory test results, and during interview confirmed that results were monitored to ensure timely treatment and resolution of any infections.</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>A suite of infection prevention and control procedures that are relevant to the type of service are available. Interviews with staff confirmed that they were aware of these policies and knew how to access them. Observation during the audit evidenced staff compliance with standard precautions. Not all hard copy infection control policies were current (refer to 1.2.3.4).</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>PA Low</p>	<p>Staff interviewed confirmed they had received infection control education, they were able to describe the principles of infection control such as hand hygiene (verified by records sighted). The IPCC stated that education provided to residents included: hand hygiene; coughing etiquette; and eye hygiene, this was confirmed during resident interviews. There was no documented evidence that the IPCC has completed a comprehensive infection control education since their appointment to this position.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to the size and complexity of the service, and includes but is not limited to urinary tract infection, respiratory tract infection, skin and wound, eye and gastro enteritis. All infections are logged into a surveillance spreadsheet, which is sent to the infection control quality manager at head office and is then correlated and analysed to identify trends (refer to 1.2.3.6).</p> <p>Residents with an infection have their care-plans discussed at handovers, to ensure consistency of care. Clinical files reviewed confirmed that short-term care plans for residents with an infection were present.</p> <p>Interviews with staff confirmed they were aware of residents with infections, were able to discuss the care required to treat the infection and reduce the chance of a recurrence of the infection. Staff also confirmed they were provided information at meetings regarding the incidence and type of infections acquired by the residents.</p> <p>There was a norovirus outbreak in October 2019, this was reported to the public health unit of the DHB. Processes were implemented to restrict the spread, which included isolating affected residents and use of isolation trolleys.</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>There is a restraint minimisation policy which meets the requirements of the standard and provides guidance on the safe use of both restraints and enablers. A restraint coordinator, the CSM, provides support and oversight for enabler and restraint management. During interview the coordinator demonstrated a sound understanding of the organisation's policy and associated roles and responsibilities.</p> <p>All clinical staff receive education on restraint and enabler use at orientation and annually, confirmed by records sighted. Education is also included on de-escalation and challenging behaviours.</p> <p>On the day of audit, there were no residents using either a restraint or requesting an enabler.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.4</p> <p>There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>	PA Low	<p>A current document control policy explains the system to manage the organisation policies and procedures available to staff.</p> <p>Managers, nurses and the administration person interviewed verified that they have access to current electronic copies of UCG documents, and that they are alerted to changes of policies in due course.</p> <p>A sighted hard copy policies manual is available to all staff. Staff acknowledgment of new printed policies is recorded on quality control sheets. However, the observed manual did not consistently reflect the latest versions of policies and forms.</p>	<p>Hard copy policies and procedures available in the facility do not consistently evidence the latest version of the document.</p>	<p>Ensure all hard copies of policies and procedures available to staff reflect current documentation.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement</p>	PA Moderate	<p>Quality data collected and observed includes but is not limited to: clinical indicators of falls; pressure injuries; skin tears; medication events; unexplained</p>	<p>Quality improvement</p>	<p>Ensure quality improvement</p>

<p>data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>		<p>weight loss; infections; and non-clinical indicators of hazards and incidents; education attendances and residents' satisfaction. Data is required to be logged into an electronic system that supports a reporting process to the FM and the regional manager. However, review of documentation and management interviews evidenced that internal audits were not always implemented according to the documented electronic schedule, and that electronic data included for analysis was not always accurate, for example for staff education data and residents' falls.</p> <p>Documented resident and family satisfaction surveys are conducted annually. Feedback from YPDs is captured through the satisfaction surveys for all residents, and the YPD interviewed confirmed they give continuous one-on-one feedback to the staff and managers. Results from the last residents' satisfaction survey generated corrective plans on the food service and the maintenance of grounds and gardens (refer to 1.2.3.8), with evidence of actions being implemented.</p> <p>The facility's quality results are analysed through trends and comparisons with national benchmark for all UCG facilities. Interviewed managers explained the quality reports they compile and review. However, not all clinical indicators were systematically evaluated through self-reflection reports. Evaluation of outcomes from residents' satisfaction surveys; quality projects; internal audits; was not systematically documented in the relevant reports. Quality meetings' summations did not consistently reflect discussion of the corrective actions from internal audits; clinical self-reflections; and incidents reviews.</p> <p>Staff meeting minutes were identified to be available to view in the staff room. However, meetings minutes for all staff did not consistently reflect the discussion of quality achievements or corrective actions from the quality meetings.</p>	<p>data is not consistently reported, evaluated, and communicated to service providers.</p>	<p>data is consistently reported, evaluated, and communicated to service providers.</p> <p>90 days</p>
<p>Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or</p>	<p>PA Moderate</p>	<p>A documented gap analysis and action plan to improve the quality management systems has been developed for the next twelve months. However, the correction actions from the gap analysis were yet to be fully implemented as verified through interview with the roving FM.</p> <p>There was no consistent evidence of corrective actions being developed from issues raised at health and safety meetings, that included an action plan, a person responsible, and a timeframe. Not all issues identified in residents'</p>	<p>A corrective action plan addressing the areas identified as requiring improvement is not consistently</p>	<p>Implement a corrective action plan addressing all areas identified as requiring improvement.</p>

requirements is developed and implemented.		satisfaction surveys, internal audits, reports' and quality meetings (including falls' incidents) had a documented corrective action plan, and some documented corrective actions had no evidence of follow up, re-evaluation or close-off.	implemented from meetings, residents' surveys, residents' incidents reports and internal audits.	90 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 an open disclosure policy in place which encourages the reporting of incidents that can cause actual or potential harm to residents. Interviews with care staff demonstrated their understanding of the reporting and escalation process. Accident/incident forms were observed to be accessible to nursing staff and completed when required. Families are informed of adverse events, as confirmed in clinical records and during residents' interviews. Immediate responses to events are documented.</p> <p>However, neurological observations in response to unwitnessed falls were not always conducted as per policy.</p>	Unwitnessed falls records do not consistently evidence neurological observations.	<p>Ensure neurological observations are conducted and documented post 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 meet the needs of the consumer.</p>	PA Moderate	<p>Residents' initial assessments and initial care plans are completed on the residents' admission to the facility. The residents' clinical records sampled, evidenced that not all residents had interRAI assessments and long-term care plans completed within 21 days of their admission.</p> <p>Delay in call bell response had been identified in the results of 2019 residents' surveys and only half of the survey results indicated the residents were satisfied that staff provide assistance in a reasonable timeframe. However, there had been no corrective action developed from this survey (refer to 1.2.3.8). The uncollated residents survey results reviewed for 2020 recorded similar results for satisfaction ratings for this question.</p> <p>There were two complaints sighted relating to delays in call bell response times. The complaints were addressed as per Right 10 of the Code, however, there was no evidence of a systemic response to this issue.</p>	<p>i) Not all interRAI assessments and care plans are completed within 21 days of admission.</p> <p>ii) Staff response to call bells was not always actioned promptly.</p>	<p>i) Ensure all interRAI assessments and care plans are completed within 21 days of the residents' admission.</p> <p>ii) Ensure call bells are answered promptly by</p>

		<p>Staff interviews described difficulties in responding and providing assistance to residents at times due to workload and acuity.</p> <p>On audit days it was observed that the call bells were heard to be activated for extended periods before being answered by staff. Residents and family interviewed reported that call bells take up to 30 minutes to be answered by staff.</p>		<p>staff.</p> <p>90 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA</p> <p>Moderate</p>	<p>The medical services evaluations are completed within the required timeframes by the GP.</p> <p>Not all clinical files reviewed had interRAI reassessments completed six-monthly nor were all the long-term care plans evaluated at six-monthly intervals. The activities care plans were not always evaluated at the same time as the nursing care plans.</p>	<p>i) Not all interRAI reassessments were completed and long-term care plans were not consistently evaluated within required six month timeframes.</p> <p>ii) The activities care plans were not always evaluated at the same time as the nursing care plans.</p>	<p>i) Ensure the interRAI reassessments and the long-term nursing care plan are completed six-monthly.</p> <p>ii) Ensure that the activity care plan is evaluated and reviewed each time the long-term care plan is reviewed.</p> <p>90 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the</p>	<p>PA</p> <p>Moderate</p>	<p>A maintenance person is employed five days a week for the facility. External contractors are responsible for the testing of biomedical and non-medical equipment. Visible condition of buildings, furnishing and care equipment met requirements. Reactive maintenance processes were identified through observation and interview. Maintenance requests from staff and residents evidenced they are collected daily, filed, actioned, and signed off. However, there is no documented preventative maintenance schedule for the building, equipment and outdoor areas.</p>	<p>i) Hot water temperatures at the sanitary fixtures accessed by residents are not consistently monitored and</p>	<p>i) Ensure hot water temperatures are monitored and maintained within safe levels.</p> <p>ii) Develop and</p>

needs of the consumer/group.		<p>Calibration of the digital probe used to assay the temperatures of fridges, rooms and hot water throughout the facility was demonstrated by the maintenance person. However, the medication room temperature was not monitored as per best practice recommendations for medicine storage areas.</p> <p>Hot water temperatures delivered at sanitary fixtures used by residents for personal hygiene were inconsistently documented since the last audit. Hot water temperatures recorded above the safe limit had no written evidence of implemented actions to minimise the risk of harm to residents. There was no evidence of interventions being implemented to correct the hot water temperatures that exceeded safe level at the delivery points accessed by residents and that presented a risk of scalding. Hot water temperature tested by the audit team at random hot taps and at different times of the day confirmed it could be burning to touch. Interview confirmed that the plumbing system had not been verified to temper the hot water temperatures that regularly exceeded the required level and included of instances of temperatures above 55 degrees Celsius for example.</p> <p>On the day of audit, the maintenance person and roving FM verified the hot water temperatures with a validated calibration probe in key residential areas and reported that: three out of six randomly sampled temperatures superseded the required limit by one to two degrees; and one of 53 degrees Celsius for a shared basin in a common area. This issue was escalated to UCG national management. A plan was articulated and observed to restrict residents' free access to hot showers/hot taps until the hot water system was urgently serviced. The plan includes increased frequency of hot water monitoring, documentation, and implementation of corrective actions until sustainable resolution can be evidenced.</p>	<p>exceed safe levels.</p> <p>ii) There is no evidence of a documented preventative maintenance plan for the facility buildings, equipment, and external grounds.</p> <p>iii) There is no evidence of the medication room temperature being monitored.</p>	<p>implement a preventative maintenance plan that minimises the risk of environmental harm to residents.</p> <p>ii) Ensure medication room temperatures are monitored and maintained within acceptable levels.</p> <p>7 days</p>
<p>Criterion 3.4.1</p> <p>Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.</p>	PA Low	<p>The IPCC has held the position since July 2019. They have completed approximately one hour of online training. The IPCC provides infection prevention and control education for staff at the facility.</p> <p>There was no documented evidence that the IPCC had completed infection and control education specific to the role.</p>	The IPCC has not completed infection prevention and control education for the infection prevention and	Ensure the infection prevention and control education to staff is provided by a suitable qualified

			control role.	person with knowledge of current practice. 90 days
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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.