The Ultimate Care Group Limited - Ultimate Care Maupuia

Introduction

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

The audit has been conducted by 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 Maupuia
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 19 January 2021 End date: 20 January 2021

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: 22

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 Maupuia provides rest home and hospital level care for up to 31 residents. There were 22 residents at the facility on the first day of the audit.

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

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

The area requiring improvement relating to care plans at the previous certification has been closed. Areas identified as requiring improvement at this surveillance include: first aid certificates and service provision requirements.

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.

Open communication between staff, residents and family is promoted. There is access to interpreting services if required.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The Ultimate Care Group is the governing body responsible for the services at this facility. There are systems in place for monitoring the services provided, including regular monthly reporting to the Ultimate Care Group national support office.

The facility is managed by an appropriately qualified and experienced facility manager who is supported by a registered nurse, team leader. Ultimate Care Group's national executive and regional teams support the service.

There is an internal audit programme, risks are identified, and a hazard register is in place. Adverse events are documented in an electronic database. Facility meetings are held and there is reporting on various indicators, quality and risk issues and discussion of identified trends. Graphs of clinical indicators are available for staff to view along with meeting minutes.

Human resource policies and procedures are documented and reflect best practice. The orientation programme is undertaken by newly recruited staff and is appropriate to their role. Practising certificates for staff and contractors are validated annually for those that require them.

There is a documented rationale for determining staffing levels and skill mixes, that is based on best practice.

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.

Registered nurses assess residents on admission. The initial care plan guides care and service provision during the first three weeks after a resident's admission.

The interRAI assessment is used to identify residents' needs; these are completed within the required timeframes. The general practitioner completes a medical assessment on admission and reviews occur thereafter on a regular basis.

Long-term care plans are developed and implemented within the required timeframes, they are individualised and based on an integrated range of clinical information. Residents' needs, goals and outcomes are identified. All residents' files reviewed demonstrated evaluations were completed at least six-monthly. Residents and their relatives are involved in the care planning process and notified regarding any changes in a resident's health status.

Short-term care plans are in place to manage short-term issues or problems as they arise. Handovers between shifts guide continuity of care and team work is encouraged.

An electronic medication management system in place. Review of the medication management system confirmed processes and practices are in line with the legislation and contractual requirements. Medications are administered by registered nurses and an enrolled nurse who have completed current medication competency requirements.

The activity programme is managed by a diversional therapist. The programme provides residents with a variety of individual and group activities and maintains their links with the community. The service uses its facility van for outings in the community.

The food service meets the nutritional needs of the residents. All meals are prepared on-site. The service has a current food control plan. Kitchen staff have food safety qualifications. The kitchen was clean and meets food safety standards. Residents and family confirmed satisfaction with meals provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

There is a current building systems status report.

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.

Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the restraint coordinator who is a registered nurse. On the day of the on-site audit no restraints or enablers were in use. Restraint is only used as a last resort when all other options have been explored. Enablers are voluntary.

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 control programme is appropriate to the size and complexity of the service. The infection control nurse is a registered nurse. Infection data is collated, analysed, trended and benchmarked. Monthly surveillance data is reported to staff and to the Ultimate Care Group national office. 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	15	0	1	1	0	0
Criteria	0	39	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Policies and procedures relating to complaints management are compliant with Right 10 of the Code. Systems are in place that ensure residents and their family are advised of the complaint process and the Code on entry to the facility. The complaints forms are displayed and accessible within the facility. Staff interviews confirmed their awareness of the complaints process. Residents and family interviewed confirmed an understanding and awareness of these processes. The facility manager (FM) is responsible for complaints management. The complaints register reviewed showed that six complaints had been received over the past year and that actions taken, were documented and completed within the required timeframes. Action plans showed that required follow up and improvements have been made where possible. There is one open complaint with the Health and Disability Commissioner, dated August 2018, currently under investigation. This is being managed by Ultimate Care Group (UCG) national office executive team, additional information was supplied when requested in a timely manner. There are no other complaints with other external agencies.
Standard 1.1.9: Communication Service providers	FA	Residents' records reviewed, confirmed that residents were kept informed about any changes to their status. Residents and family interviewed stated that they were advised in a timely manner about any urgent medical reviews or unexpected care situations (refer to 1.3.3.4). Staff understood the principles of open disclosure,

communicate effectively with consumers and provide an environment conducive to effective communication.		which is supported by policies and procedures that meet the requirements of the Health and Disability Services Consumers' Rights (the Code). Residents and family members are informed of residents' upcoming meetings. The resident meeting minutes reviewed evidenced that relevant information is shared. Residents' need's for interpreting services are discussed at the time of entry to the service. Access to interpreters is organised through family, community groups or the district health board (DHB). Specific care arrangements and communication, when English was not the first language for residents, were observed at audit.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Ultimate Care Maupuia's (UC Maupuia) strategic and business plan, which are reviewed annually, outline the purpose, scope, direction and goals of the facility. The organisation's values were visible on display in the reception area of the facility. The FM is responsible for the overall management of the service and has been in this role for eight weeks. The FM is a registered nurse (RN) and has previous experience in the management of residential care facilities. The required authorities have been informed of the appointment. The FM is supported by a RN team lead, who is responsible with the FM for the oversight of clinical services. The RN team lead has been in the position for eight weeks, has experience in aged residential care and has worked at UC Maupuia for twelve months as a RN. The UCG regional manager was at the facility at the time of audit. Ultimate Care Maupuia has a total of 31 beds, which includes 8 rest home and 23 dual purpose beds that are split between two floors. The lower level can accommodate 8 rest home beds, and the 23 dual purpose beds are located on the main level. At the time of audit there were a total of 22 residents in the facility, 11 receiving hospital level care and 11 receiving rest home level care. Twenty residents were located on the main level this included nine rest home care (including one married couple who shared a double room) and eleven hospital level residents. Two rest home residents were located on the lower level. The facility holds contracts with the DHB for the provision of rest home, hospital, medical and day care services. There were no residents under the age 65 years of age or boarders at the time of audit.
Standard 1.2.3: Quality And	FA	Ultimate Care Maupuia utilises the UCG quality and risk management systems, that reflect the principles of

Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		continuous quality improvement. All policies are subject to reviews as required and all policies are current. National office executive team reviews all policies with input from relevant staff and management. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation and evidenced-based practice guidelines. Polices are readily available to staff. New and revised policies are presented at staff meetings (sighted) and policy updates are also provided as part of relevant in-service education. Staff interviewed confirmed that they are provided with copies of new and revised policies and opportunities to read and understand policy content. Service delivery is monitored through real time reporting, which includes management of incidents, complaints, audit activities, key performance activities and an annual patient satisfaction survey. The annual patient satisfaction survey indicated residents and family were happy with the services received and complementary of the food service. The internal audit programme is documented and implemented as scheduled. Audit data is collected, collated and analysed. Where improvements are required following internal audits and the patient satisfaction survey, corrective action plans are developed and implemented. Interviewed staff reported that they are kept informed of audit activities and results at staff meetings. Monthly meetings include the quality and RN meetings. Meeting minutes evidenced communication with staff around aspects of quality improvement and risk management. A review of the quality management data evidenced corrective action plans were completed using the organisation's electronic template. Documentation included the person responsible for implementation and showed that timeframes were adhered to, and the plan was completed and evaluated as to effectiveness. Ultimate Care Maupuia utilities the UCG risk management programme. Health and safety policies and procedures are documented along with hazard management programme. There was evidence of hazard identification forms completed when a hazard was identified and that hazards are addressed, and risks minimised. The maintenance person has been appointed as the health and safety officer and training is planned. The FM is providing oversight until training has been completed by the newly appointed health and safety officer. A current hazard register was sighted during the on-site visit. Staff interviewed confirmed awareness of the process to report hazards.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by	FA	Essential notification of reported events is the responsibility of the FM. The FM interviewed outlined when to report and notify statutory authorities including but not restricted to: police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury, disease outbreaks; and changes in key managers. There have been two notifications to the ministry under Section 31 since the previous audit, relating to the FMs appointment and the utilisation of an enrolled nurse (EN) for RN coverage (refer to 1.2.8.1).

the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		Staff interviewed understood the adverse event reporting process in relation to their professional practice and regulatory requirements. They were also able to describe the importance of reporting near misses. Staff who witness an event or are first to respond to an event, document the adverse, unplanned or untoward accident/incident into an electronic management system. The system documents completion of tasks such as contacting the general practitioner (GP) and/or the family members (refer to 1.3.3.4). Reported accident/incident are monitored by the national office support management team and the FM Monday to Friday. Results from accidents/incidents inform quality improvement processes and are discussed at quality meetings. Family interviewed confirmed that they were notified where the resident has had an accident or a change in health status.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Written policies and procedures in relation to human resource management are available and implemented. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice. The selection and approval of new staff is the responsibility of the FM. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities, and authority. These were reviewed on staff files along with employment agreements, reference checks, performance appraisals and police vetting. Interviews with care givers confirmed new care givers are paired with a senior care giver until they demonstrate competency of tasks including residents' personal cares. Completed competency assessments questionnaires, for relevant competencies required for specific tasks such as: orientation; hoists; handwashing; wound management: medication management; moving and handling were sighted in staff education files reviewed. There were four RNs including the FM that are interRAI competent. The organisation has a mandatory and implemented education and training programme.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service	PA Moderate	Ultimate Care Group has a national documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, 7 days a week (24/7). The national team has developed a base roster based on residents acuity. The FM oversees the roster and adjusts the staffing levels locally to meet the changing needs of the residents. The UC Maupuia policy is to have a rostered RN to cover all shifts. RN shortages, both employed RNs and agency RN staffing has resulted in a short-term issue where a RN has not been available to cover each shift. The facility notified the ministry and the DHB (Section 31) that an EN will be utilised to cover a minimal

providers.		number of shifts for a limited period of one month whist advertising and orientating for two new RNs is underway. The two new employed RNs' orientation is due to be completed within the next two weeks. Support and supervision for the EN is provided by the FM, who is on call clinically and lives close to the facility. Support on site is provided by ensuring senior care givers are rostered alongside the EN. Not all RNs rostered have a current first aid certificate. Care givers reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. The FM is on call after hours and weekends seven days a week to support the facility with emergency matters.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy was current and identifies all aspects of medicine management in line with the relevant legislation and guidelines. A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices in line with legislation, protocols and guidelines were observed. The required three-monthly reviews by the GP were recorded electronically. Resident allergies and sensitivities were documented. The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. There are no standing orders used at the facility. Review of the medication fridge evidenced that the service does not store or hold vaccines and interviews with the RN confirmed this. The medication refrigerator and drug room temperatures are monitored daily. Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration. Weekly checks and six-monthly stocktakes of medications are conducted in line with policy and legislation. The staff observed administering medication and at interview demonstrated clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures. The RNs oversee the use of all pro re nata (PRN) medicines and documentation made regarding effectiveness on the electronic medication record and in the progress notes was sighted. Current medication competencies were evident in staff files.

		There were no residents self-administering medication during the on-site audit.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals are prepared on site and served in the dining room or in the resident rooms if requested. The seasonal menu has been reviewed by a dietitian, with the summer menu implemented at the time of audit. The food control plan is current. Food management training and certificates for the chef and kitchen staff were sighted. Food temperatures are monitored appropriately and recorded. The kitchen staff have relevant food hygiene and infection control training. The kitchen was observed to be clean and the cleaning schedules sighted. A nutritional assessment is undertaken for each resident on admission by the RN to identify the resident's dietary requirements and preferences. The dietary profiles are communicated to the kitchen staff and updated when a resident's dietary needs change and when dietary profiles are reviewed six-monthly. Diets are modified as needed and the chef interviewed confirmed awareness of the dietary needs, likes and dislikes of residents. These are accommodated in daily meal planning. Residents were observed to be given sufficient time to eat their meal and assistance was provided when necessary. Residents interviewed stated that they were satisfied with the meals provided. All aspects of food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit comply with current legislation and guidelines. The cook is responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately in fridges, a freezer and cool store. Temperatures of fridges and the freezer are monitored and recorded daily. Dry food supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Long-term care plans are developed with the resident and family/whānau involvement. All residents' files sampled had an individualised long-term care plan. Long-term care plans reflect interventions identified from assessments and describe interventions in sufficient detail to meet residents' assessed needs. Short-term care plans are developed for the management of acute problems. The finding from the previous audit relating to care plans not reflecting the required interventions to achieve the outcomes from ongoing assessments is now closed. Resident files showed service integration with clinical records, activities notes, and medical and allied health professionals' reports and letters (refer 1.3.3.4). Interviews with residents confirmed that they have input into their care planning and review, and that the care provided meets their needs.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Long-term care plans are completed by the RN and based on assessed needs, desired outcomes and goals of residents. Care planning includes specific interventions for long term and acute problems. The GP documentation and records reviewed were current. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs. There is evidence of wound care products available at the facility. The review of the wound care plans evidenced that wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were recorded, and measurements taken where this was required. Staff interviews confirmed that they have access to the supplies and products they require to meet residents' needs. Monthly observations such as weight and blood pressure are completed and are up to date. Continence products are available and resident files included: urinary continence assessment; bowel management; and continence products identified for day use, night use and other management.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The residents' activities programme is implemented by a diversional therapist. Activities for the residents are provided five days a week, Monday to Friday 9:30am to 3:30pm. On Saturdays and Sundays, a range of activities are made available for residents, staff and family to access. The activities programme is displayed on the resident noticeboard. The activities programme provides variety in the content and includes a range of activities which incorporate education, leisure, cultural, spiritual and community events. Van outings into the community are arranged weekly and church services are held monthly. The residents' activities assessments contain information on the residents' interests, family and previous occupations. This information is gathered during the interview with the resident and their family and documented. The residents' activity needs are reviewed six-monthly at the same time the care plans are reviewed and are part of the formal six-monthly multidisciplinary review process. The residents and their family reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging and enjoying a variety of activities.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported at handovers. If any change is noted, it is reported to the RN. Long-term care plans are evaluated every six months in conjunction with the interRAI re-assessments or if there is a change in the resident's condition. Evaluations are documented by the RN. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Residents and family interviewed confirmed involvement in the evaluation process and any resulting

		changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building warrant of fitness was unable to be issued during the Covid-19 level restrictions. A building systems status report was issued by the local council in lieu of a building warrant of fitness. The certificate is valid for 12 months and expires November 2021. There have been no structural alterations to the building since the last audit.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Ultimate Care Group's surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal audits are completed. The infection control nurse (ICN) is a RN who has completed training for the role. The infection control committee meets three-monthly and is comprised of the ICN, FM, clinical staff, kitchen and housekeeping staff. Short-term care plans are developed to guide care and evaluate treatment for all residents who have an infection. New infections and any required management plans are discussed at handover to ensure early intervention occurs. Surveillance data is collected in the clinical areas and collated monthly by the FM and is accessed by the Ultimate Care Group national office for reporting and benchmarking. Information following monthly infection data collection is provided to staff via handover and the infection control, quality and staff meetings. There have been no outbreaks since the previous audit. Covid-19 information is available to all visitors to the facility. Ministry of Health information was available on site. There are adequate infection prevention and control resources available should a resident infection or outbreak occur.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Ultimate Care Group policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is a RN who provides support and oversight for enabler and restraint management in the facility. The restraint committee is made up of the FM, RNs and three care givers and meetings are held three-monthly. On the day of the audit there were no residents using restraints or enablers. Restraint is used as a last resort when all alternatives have been explored. This was evident from interviews

		with staff who are actively involved in the ongoing process of restraint minimisation. Regular training occurs. Review of restraint and enabler use is completed and discussed at the quality, restraint and clinical meetings.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Moderate	UC Maupuia policy is that every RN, EN, FM, activities and the maintenance person (who drives the bus) will have a current first aid certificate. This policy ensures one staff member is rostered on at all times with a current first aid certificate. The FM maintains documented evidence of the date first aid has been completed and the date due to ensure all are current. The roster was reviewed noted not all RNs rostered in the evening or night shift had a current first aid certificate.	A staff member with a current first aid certificate was not always rostered on each shift.	Ensure a staff member with a current first aid certificate is rostered on each shift. 90 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery	PA Low	Progress notes contain details of care given to residents. However, in five out of five clinical records review of the progress notes evidenced that visits from the GP were not documented, accidents and incidents were inconsistently documented and contact with family was not recorded in the progress notes or on	Family contact, accidents and incidents and GP visits were not recorded in the	Ensure all information regarding residents’ health and progress is

and promotes a team approach where appropriate.		the family contact form.	progress notes.	recorded in the progress notes. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.