

The Ultimate Care Group Limited - Ultimate Care Kensington Court

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 Kensington Court
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 March 2021 End date: 10 March 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:	54

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 Kensington Court is part of the Ultimate Care Group Limited. The facility is certified to provide services for up to 81 residents requiring rest home or hospital level services. Occupancy on the first day of audit was 54. There have been no significant changes to services at the facility since the last 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 family, residents, management, staff and a nurse practitioner.

Areas identified as requiring improvement relate to: quality management systems, performance appraisals, care planning and medication management.

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

Staff interviewed demonstrate an understanding of the residents' rights and their obligation to uphold these. Residents and family/whānau confirmed that residents' rights are upheld.

Residents have their needs met in a manner that respects their cultural values and beliefs, including residents who identify themselves as Māori. Informed consent is practised, and written consent is obtained when required.

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

Staff communicate with residents and family members following incidents and this is recorded in the resident's file. Interviews confirmed that the environment is conducive to communication and that residents' needs are taken into consideration.

A documented and implemented complaints management system aligns with Right 10 of the Code of Health and Disability Services Consumers' Rights.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Ultimate Care Group Limited is the governing body responsible for the services provided at this facility. The organisation's mission statement and vision are documented and displayed in the facility. The service has a current business plan in place.

An experienced and suitably qualified facility manager ensures the management of the facility. A clinical services manager oversees the clinical and care services. A regional clinical lead and regional manager support the facility's managers in their roles.

There is a documented quality and risk framework. Meetings are held that include reporting on various clinical indicators, and there is discussion of identified trends.

Human resource policies and procedures guide practice in relation to recruitment and orientation align with legislative requirements. Staffing rosters meet contract requirements. Staffing levels are adequate to provide the required levels of services to residents.

Systems are in place to ensure the secure management of resident information.

Continuum of service delivery

<p>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.</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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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 assessments are used to identify residents' needs; these are completed within the required timeframes. The general practitioner or nurse practitioner complete a medical assessment on admission, which is reviewed thereafter on a regular basis.

Long term care plans 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 family are involved in the care planning process and notified regarding any changes in the resident 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 teamwork is encouraged.

An electronic medication management system is in place. Medications are administered by registered nurses and health care assistants who have completed current medication competency requirements.

The activity programme is managed by a diversional therapist assisted by an activity coordinator. 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.

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 the 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.
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The facility building warrant of fitness and approved fire evacuation plan are current. Waste and hazardous substances are managed safely. Staff use protective equipment and clothing where required.

A planned, preventative and reactive maintenance programme is in place that complies with legislation and includes but is not limited to equipment and electrical checks.

Residents' rooms provide single accommodation and are of an appropriate size to allow care to be provided as needed, including the safe use and manoeuvring of mobility aids. Bathroom and showering facilities are easily accessible throughout the facility.

Cleaning and on-site laundry services, provided seven days a week by household staff, are monitored.

Essential security systems are in place to ensure resident safety. Six monthly trial evacuations are undertaken. The facility has a monitored call bell system for residents to summon help, when needed, in a timely manner.

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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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.
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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	41	0	3	1	0	0
Criteria	0	88	0	3	2	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 Kensington Court has policies, procedures and processes in place to ensure that services are provided in a manner that is consistent with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Training records and interviews verified that staff receive education on the Code as part of orientation and the mandatory annual education programme. Staff interviews confirmed their understanding of the Code and described practices that evidenced an understanding of their obligations. Evidence that the Code is implemented in everyday practice includes but is not limited to: maintaining residents' privacy; providing residents with choices; involving family/whānau and residents in decision making; and ensuring residents are able to practise their personal values and beliefs.</p> <p>Resident and family interviews, and observations confirmed that services are provided in a manner that upholds resident dignity and maintains their privacy. Family and resident interviews confirmed that they receive information relevant to their needs.</p>
<p>Standard 1.1.10: Informed Consent Consumers and where appropriate</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</p>

<p>their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>definition of consent and how this is facilitated and obtained.</p> <p>All staff interviewed, including non-clinical staff, demonstrated they are cognisant of the procedures to uphold informed consent.</p> <p>The RNs stated that they discuss informed consent with residents and family during admission and care planning. This includes consent for resuscitation and advance directives. File reviews and staff interviews demonstrated that advance directives, resuscitation orders and EPOA were completed and documented for residents in accordance with policy. Observations evidenced that residents or their EPOA sign informed consents in line with legislation.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>There is an advocacy policy and procedure to ensure that residents and their family have a right to be represented and to express views or concerns about their situation. It includes making residents aware of the availability of advocacy services and supporting access to those services.</p> <p>The complaints policy includes making residents aware of their right to advocacy when making a complaint.</p> <p>Interviews with residents and family confirmed that they were aware of the right to advocacy.</p> <p>Interview with an RN advised that advocacy services had been sought from a local advocacy service for residents when required or requested.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Observations, and resident and staff interviews confirmed that residents have access to visitors of their choice. There are areas in the facility where residents and family/whānau can meet in private. Interviews with residents and family, as well as observations, confirmed that family were welcome in the facility and free to visit at any time.</p> <p>Interviews with residents and staff confirmed that residents are free to leave the facility and are supported visit to their family or go on shopping trips, for example. The activities programme, and the content of care plans include outings in the community.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected,</p>	<p>FA</p>	<p>The service has a policy to ensure that complaints are managed in line with Right 10 of the Code. Residents stated that they were aware of the complaint process and they knew how to access information would they wish to make a complaint. Complaint forms and a complaint box were sighted in resident areas inside the facility.</p>

and upheld.		<p>Review of the complaints register and associated complaint forms indicated that complaints were processed and documented in a timely manner and as per policy. The register was current for all complaints, including investigations, outcomes and communication progress date. Written responses, investigations and corrective actions were issued in response to complaints, with evidence of implemented improvements/problem resolution.</p> <p>The regional manager (RM) and the facility manager (FM) advised that there had been one complaint made to the Health and Disability Commissioner (HDC) since the previous audit, related to resident cares. Ultimate Care Group head office had responded to the HDCs request for information and was awaiting an outcome.</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 the facility. Residents/family receive an information pack that includes information on the Code, advocacy services and the complaints process. During the admission process, the clinical services manager (CSM) or a registered nurse (RN) explains the information provided to residents and family in the information pack to ensure understanding.</p> <p>Resident interviews confirmed they understand their rights and they felt that staff upheld these.</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 organisation has policies and procedures that align with the requirements of the Privacy Act and Health Information Privacy Code to ensure that resident's rights to privacy and dignity are upheld.</p> <p>Staff interviews and observations confirmed that resident confidentiality was maintained. Resident and family interviews confirmed that resident privacy was respected. Staff were observed to knock on bedroom doors prior to entry, to take residents to the bathrooms suitably attired and covered, and ensured that doors were shut when personal cares were being provided.</p> <p>The organisation has a policy on sexuality and intimacy that provides guidelines for staff in managing expressions of sexuality. Resident and family interviews and observations confirmed that residents had access to a hairdressing salon at the facility and could wear clothing and makeup of their choice. Staff interviewed were aware of residents' individual preferences and provided examples of facilitating favourite activities.</p> <p>Review of residents' files and interviews with resident and family/whānau confirmed that individual cultural, religious, social preferences, values and beliefs were identified, documented and upheld.</p> <p>An abuse and neglect policy sets out the guidelines to prevent, identify and report any incidences of abuse and neglect. Staff receive orientation and mandatory annual training on abuse and neglect.</p>

		Review of documentation and interviews with staff and residents/family confirmed 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 how UCG responds to Māori cultural needs and beliefs in relation to illness. Staff receive training on the Treaty of Waitangi and cultural safety as part the mandatory annual education programme. The cultural needs of residents and their whānau are documented in mandatory admission assessments.</p> <p>There was one resident who identified as Māori and their cultural needs were included in documented assessments and care plans.</p> <p>Staff interviews described awareness of the individual needs of the Māori resident. Support for staff in providing culturally appropriate care and support for Māori residents and their family, would be sourced externally or accessed through UCG when required. Interviews with staff also confirmed awareness of the importance of involving whānau in the delivery of care.</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>Staff, resident and family interviews confirmed that residents are provided with choices regarding their care and the services provided.</p> <p>Information gathered during assessments includes identifying a resident's specific cultural needs, values, and beliefs, as well as spiritual and cultural preferences. This information ensures activities are tailored to meet identified needs and preferences. For residents who wish to attend, there are regular church/religious services.</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>There are implemented policies and processes to ensure that residents are free from discrimination, coercion, harassment, and financial exploitation. Staff interviews confirmed awareness of their obligation to report any evidence of discrimination, harassment and exploitation.</p> <p>Staff signed sighted agreements, defining the standards of conduct, as part of their employment documentation.</p> <p>Interviewed staff confirmed understanding of professional boundaries relevant to their respective roles. Resident interviews confirmed that staff acted professionally and maintained appropriate boundaries.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The facility implements UCG policies and procedures. These are based on current evidence-based practice, legislation and guidelines, and align with the Health and Disability Services Standards.</p> <p>Clinical consultation and expertise are available through UCG clinical leadership to guide implementation of good practice as per policy.</p> <p>Staff and resident interviews, progress notes in residents' file and observation of service delivery confirmed that resident care was based on good practice guidelines.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The organisation has an open disclosure policy that promotes a transparent, consistent approach to full disclosure where there is a harmful event during 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 the resident enduring power of attorney (EPOA) or next-of-kin are informed when required.</p> <p>Meeting minutes and interviews with residents confirm that they are able to participate in residents' meetings and discussions. The facility also provides family and residents with access to a secure social media page, that provides members with updates on activities and events within the facility. Residents sign consent for use of their photos on this medium.</p> <p>There were no residents who required the services of an interpreter at the time of audit. Staff interviews advised that interpreter services would be sourced through the local district health board (DHB) if required.</p> <p>Residents interviewed stated that staff were approachable to respond to questions and that they were satisfied with the responses provided.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Ultimate Care Kensington Court is part of UCG with the executive team providing direction to the service. The organisation's strategic direction/goals that are current and regularly reviewed. The UCG director of nursing and wellness supervises clinical governance and management nationally for each facility. The FM reports to a RM who oversees the facility's quality and operational performance. The regional clinical lead supports the clinical operations at the facility. The RM holds a weekly meeting with all of the FMs and CSMs in the region and visits the facility in person three-monthly, in addition to providing ongoing remote support. The RM provided on-site support to the facility during the audit.</p> <p>The organisation has a documented vision, mission and values statement. The organisation values</p>

		<p>were displayed in the facility and in information available to residents and family.</p> <p>The FM is a RN who has been in the role for 18 months and has previous management and age-related care experience. The CSM, also a RN, has held this position for over two months and has previous experience in a CSM role. Both managers have current annual practicing certificates.</p> <p>The service provides rest home and hospital level care for up to 81 residents. Services are provided over 16 hospital level beds, 18 dual purpose beds, 23 rest home only beds and a wing of 24 rest home level apartments/studios.</p> <p>At the time of the audit, there were a total of 54 residents, 21 receiving hospital level care and 33 receiving rest home level care. Included in these numbers were four residents in apartments/studios with occupational rights agreements (ORAs), assessed as requiring rest home level care. The service holds sighted contracts with the DHB for age-related care, respite care and day care. At the time of audit there were no residents accessing the respite or day care services.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The FM advised that in the short absence of the FM, the CSM would be responsible for the management of the facility. In the short absence of the CSM, a senior RN would cover the CSMs role. The RM would also provide support to staff during absences of the FM or CSM. In the advent of a longer absence of either the FM or CSM a temporary manager would be arranged through UCG.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>Ultimate Care Group has an annual quality and risk management plan that guides the quality and risk management systems/processes to be implemented in the facility. The plan supports continuous quality improvement through the implementation of quality and risk programmes such as a schedule of audit, quality projects, training, risk management reviews, meetings and reporting. Data sighted evidenced monitoring, analysis and reporting for quality improvement purposes. The quality improvement system is executed at the facility through the monitoring, analysis, planning and implementation of corrective actions. However, reviewed documentation evidenced that the outcomes of the implemented quality management systems and processes were not consistently recorded.</p> <p>Resident satisfaction surveys are performed twice a year and included in audit reporting. Reviewed results and resident interviews confirmed satisfaction with service provision.</p> <p>A document control policy is in place to ensure that current UCG organisation-wide policies and</p>

		<p>procedures are regularly reviewed and accessible.</p> <p>The organisation has a risk management programme in place that records risks, severity, and mitigation in clinical, environment, human resource and other areas specific to the facility. Health and safety policies and procedures are documented along with a current hazard register. Health and safety outcomes are monitored as part of the annual internal audit programme, events are discussed at health and safety meetings. Staff interviews advised that they are encouraged to report hazards immediately and there was documented evidence that identified hazards are addressed promptly and risks minimised.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Managers interviewed described awareness of their responsibilities in relation to essential notification and incident reporting. Notifications to HealthCERT under Section 31 were noted for the appointment of the FM, acting CSMs and the new CSM.</p> <p>There is an electronic system to record resident clinical incidents/accidents. Review of incident records indicated that whenever possible, family or emergency contacts are informed of unanticipated events and changes in a resident's clinical condition. Staff interviewed confirmed that clinical incidents/accidents are notified to the RN in charge in a timely manner. The general practitioner (GP) is notified when required. Clinical incidents/accidents reviewed evidenced documentation by staff and evaluation by the CSM (refer to 1.2.3.8). Associated progress notes recorded the detailed interventions commenced. Neurological observations were completed for unwitnessed falls and suspected head injuries as per best practice.</p> <p>Regular review, analysis and reporting on recorded incidents provides information that informs quality management decisions for the facility.</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>	PA Low	<p>Human resources documented processes adhere to the principles of good employment practice and the Employment Relations Act 2000. Review of staff records confirmed the organisation's policy is consistently implemented and records are maintained. The recruitment processes include: police vetting, reference checking and a signed contract agreement with a job description. Current practicing certificates were sighted for all staff and contractors who require these to practice. Personnel involved in driving the van held current driver licences. Non-clinical staff include household and laundry personnel, a maintenance person, a part-time gardener, and kitchen staff.</p> <p>There is a documented and implemented orientation programme. There was recorded evidence of staff receiving an orientation specific to their roles with a generic induction component. Staff interviews confirmed completing this and stated that it was appropriate to their role.</p>

		<p>There is an implemented annual training programme. Staff competencies and education scheduled are relevant to the needs of aged-care residents, including those receiving hospital level care. However annual performance appraisals were overdue.</p> <p>Seven of eight RNs are interRAI trained and one is in the process of training. Health care assistants (HCA) complete Careerforce training or an equivalent.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Duty rosters are completed by the FM and administrator and are guided by a documented base roster. The FM explained that rostering was based on the occupancy in the facility; the level of acuity; the skill mix and experience of staff; and the daily workload. The rosters sighted meet the age-related residential care services agreement requirements.</p> <p>The facility aims to have two RNs on the roster to cover the morning and afternoon shifts and one RN on duty at night across the facility. A sample of rosters established that RN cover is ensured 24/7 and unplanned staff absences are filled in by part-time staff. There have been instances (between one and up to two shifts per week) over the previous four rosters where there has been only one RN on the roster on a morning or an afternoon shift. In these instances, an additional senior, medication competent HCA has been rostered on to support the RN. Across the facility there are eight HCAs, with a mix of long and short shifts rostered in the morning and afternoon shifts and two at night, seven days per week. There are two nurses' stations. When there is one RN on duty, the RN is based in the nursing station in the hospital wing. The four residents with ORA in the apartments/studios are situated near to, and easily assessable from, the rest home wing.</p> <p>The FM and CSM are rostered on call 24/7 to support the facility after hours.</p> <p>Residents interviewed stated they were satisfied with level of care provided by staff.</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>	FA	<p>Residents' records and medication charts are managed electronically. Residents' information, including progress notes, are entered into the resident's record in an accurate and timely manner. The name and designation of the person making the entry is identifiable. Residents' progress notes are completed every shift, detailing resident's response to service provision.</p> <p>There are policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff interviews confirmed an awareness of their obligations to maintain the confidentiality of resident information. Resident care and support information can be accessed in a timely manner and is protected from unauthorised access. Electronic password protection and any hard copy information is locked away when not in use. Documentation containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the</p>

		<p>public.</p> <p>Each resident's information is maintained in an individual, uniquely identifiable record. Records include information obtained on admission, with input from the resident's family and resident where applicable.</p> <p>The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Needs Assessment and Service Coordination (NASC) assessments are completed for entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the resident's level of care requirements. Review of residents' files confirmed entry to service processes are implemented, ensuring compliance with entry criteria. Interviews with residents and review of records confirmed the admission process was completed by staff in a timely manner.</p> <p>Residents and family interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</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>Transition, exit, discharge or transfer is managed in a planned and coordinated manner.</p> <p>Interviews with RNs and review of residents' files confirmed there is open communication between services, the resident, and the family/whānau. Relevant information is documented and communicated to health providers. A transfer form accompanies residents when a patient is moved to another service or facility. Follow-up occurs to check that the resident is settled.</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>	PA Moderate	<p>A current medication management policy identifies all aspects of medicine management in line with the relevant legislation and guidelines to guide practice.</p> <p>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 on the electronic medication chart.</p> <p>The service uses pharmacy pre-packaged medicines. All stock medications sighted were within</p>

		<p>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. However, medications delivered by the pharmacy were not consistently checked against the medication chart prior to administration.</p> <p>Review of the medication fridge evidenced that the service does not store or hold vaccines. The medication refrigerator and medication room temperatures are monitored daily.</p> <p>Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration when required. Weekly checks and six-monthly stocktakes of medications are conducted in line with policy and legislation.</p> <p>The staff observed administering medication demonstrated 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. Documentation made regarding PRN effectiveness on the electronic medication record and in the progress notes was sighted. Current medication competencies were evident in staff files.</p> <p>There were three residents self-administering medication during the on-site audit. Safe storage was provided. However, competency assessment by the GP and recording of PRN usage by residents self-administering medication was inconsistent.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals are prepared on site and served in the dining rooms 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.</p> <p>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.</p> <p>A nutritional assessment is undertaken for each resident on admission by the RN to identify the residents' dietary requirements and preferences. The dietary profiles are communicated to the kitchen staff and updated when a resident's dietary needs change, and six-monthly when residents' dietary profiles are reviewed. Diets are modified as needed and the cook interviewed confirmed awareness of the dietary needs, likes and dislikes of residents. These are accommodated in daily meal planning.</p> <p>Residents were observed to be given time to eat their meal and assistance was provided when necessary. Residents and family interviewed stated that they were satisfied with the meals provided.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal sighted at</p>

		<p>the time of the audit complied 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 a 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.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service has a process in place if access is declined. When residents are declined access to the service, residents and their family/whānau, the referring agency and GP are informed of the decline to entry. The resident would be declined entry if care requirements are not within the scope of the service or if a bed is not available.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The initial nursing assessments which include dietary needs, pressure injury, falls risk and continence needs are completed within 24 hours of admission. The initial care plan guides care for the first three weeks (refer to 1.3.3.3). Registered nurses complete the interRAI assessment within the required timeframes. The long-term care plan is based on the interRAI assessment outcomes. Assessments are recorded, reflecting data from a range of sources, including: the resident; family/whānau; the GP/NP and specialists.</p> <p>Policies and protocols are in place to ensure continuity of service delivery. Interviews with residents and family confirmed their involvement in the assessments, care planning, review, treatment, and evaluation of care.</p> <p>All residents have current interRAI assessments completed by a trained interRAI assessor on site.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Long-term care plans are developed with resident and family/whānau involvement. All residents' files sampled had an individualised long-term care plan (refer to 1.3.3.3). Long-term care plans describe interventions in detail to meet residents' assessed needs. Short-term care plans are developed for the management of acute problems.</p> <p>Review of resident files in the electronic system showed service integration with clinical records, activities notes, and medical and allied health professionals' reports and letters. Interviews with residents confirmed that they have input into their care planning and reviews, and that the care provided meets their needs.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Long-term care plans are completed by RNs and based on assessed needs, desired outcomes and goals of residents. Care planning includes specific interventions for long-term problems. Short-term care plans are in place for acute problems, for example infections.</p> <p>The GP/NP documentation and records reviewed were current. The NP interviewed verified that medical orders are followed, and care is of a high standard. A range of equipment and resources were available, suited to the levels of care provided and in accordance with resident's needs.</p> <p>Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs. There is evidence of wound care products available at the facility. The review of the wound care plans evidenced wounds are assessed in a timely manner and reviewed at appropriate intervals. Photos were recorded and measurements taken where this was required. Where wounds required additional specialist input, this was initiated.</p> <p>Monthly observations such as weight and blood pressure are completed and are up to date. Continence products are available and residents' files included urinary continence assessments, bowel management and continence products identified for day use, night use and other management.</p> <p>The nursing progress notes are recorded and maintained. Family communication is recorded in the progress notes. Interviews with residents and family confirmed that care and treatment met residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The residents' activities programme is implemented by a diversional therapist who is assisted by an activities coordinator. Activities for residents are provided 5 days a week, Monday to Friday 8:30am to 4:30pm. On weekends, a range of activities are made available for residents, staff and family to access. The activities programme is displayed on the resident noticeboards. The activities programme provides variety in the content and incorporate education, leisure, cultural, spiritual and community events.</p> <p>The residents' activities assessments are completed following the residents' admission to the facility in conjunction with the admitting RN. Information on the residents' interests, family/whānau and previous occupations 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.</p> <p>The residents and family member reported satisfaction with the activities provided. Over the course</p>

		of the audit residents were observed engaging in a variety of activities.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it is reported to the RN.</p> <p>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 the desired goals and outcomes.</p> <p>Residents and family interviewed confirmed involvement in the evaluation process and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Where needed, referrals are sent to ensure other health services, including specialist care is provided for the resident. Referral forms and documentation are maintained on resident files. Referrals are regularly followed up. Communication records reviewed in the residents' files, confirmed family/whānau are kept informed of the referral process.</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>	FA	<p>The facility implements UCG waste and hazardous management policies that conform to legislative and 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>Current material safety data posters are available and accessible to staff in relevant places in the facility, such as the sluice room. Staff complete a chemical safety training module on orientation.</p> <p>Staff receive training and education in waste management and infection control as a component of continuous education.</p> <p>Interviews and observations confirmed that there is enough PPE and equipment provided to protect staff, residents and visitors from risks of cross-contamination. Interviews and observations confirmed that the use of PPE is appropriate to the recognised risks.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness was displayed in the entrance to the facility. Buildings, plant, and equipment comply with relevant legislation.</p> <p>A preventative and reactive maintenance schedule is implemented. This includes monthly maintenance checks of all areas and specified equipment such as hoists. Staff identify maintenance issues on an electronic system. This information is reviewed daily, or more frequently, by the maintenance person and attended to as required. Interviews confirmed staff awareness of the process for maintenance requests and that repairs were conducted in a timely manner.</p> <p>Interviews with staff and visual inspection confirmed there is adequate equipment available to support care. The facility has an up to date annual test and tag programme. Evidence of checking and calibration of biomedical equipment, such as hoists was sighted. There is a system to ensure that the facility van that is used for residents' outings is routinely maintained. Inspection confirmed that the van has a current registration, warrant of fitness, first aid kit, fire extinguisher and functioning hoist. Hot water temperatures are assayed monthly. A review of temperature assays and interview with the maintenance person confirmed that where hot water temperatures are outside the recommended safe range, action is taken by a plumber.</p> <p>All resident areas can be accessed with mobility aides. All external courtyards and decked areas have outdoor seating and shade and can be accessed freely by residents and their visitors, including by residents who need mobility assistance.</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>	<p>FA</p>	<p>There are adequate numbers of accessible showers, hand basins and toilets throughout the facility, with a combination of ensembles, communal toilet/bathing facilities and visitors' toilets.</p> <p>Communal toilets have a system to indicate vacancy and have disability access. Visitors' toilets and residents' toilets are located close to communal areas. All shower and toilet facilities have call bells; enough room; approved handrails; and equipment to promote mobility and independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>Residents have their own room, and each provides space for residents to mobilise with mobility aids and assistance. There are 23 rooms used for rest home only residents. All hospital and dual purpose rooms have space to accommodate the use of a hoist. Observations and interviews with residents confirmed that there was enough space to accommodate: personal items; furniture; equipment and</p>

<p>adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>assisting staff as required.</p> <p>Residents and their family can personalise the resident's room.</p> <p>There are designated areas within the facility to store equipment such as wheelchairs, walking frames, commodes and hoists.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There is a dining room lounge at each end of the facility and a central kitchen. There are a number of small nooks with seating and areas available for residents to access with their visitors for privacy, if they wish. All internal communal areas have seating and external views. Areas can be easily accessed by residents, family and staff. Observation and interviews with residents and family confirmed that residents can move freely around the facility and that the accommodation meets residents' needs.</p> <p>There are areas in each wing, including lounge areas, that are used for activities.</p> <p>Most residents were observed to have their meals with other residents in the communal dining rooms but can have their meal in their own room if they wish.</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 rostered each day. Visual inspection of the on-site laundry demonstrated the implementation of a clean/dirty process for the hygienic washing, drying and handling of personal clothes and facility linen. The safe and hygienic collection and transport of laundry items into relevant colour containers 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 family confirmed satisfaction with laundry services in interviews and in satisfaction surveys.</p> <p>Cleaning duties are performed by two cleaners according to documented procedures to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. Household personnel interviewed were aware of the requirement to keep their cleaning trolleys in sight. 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>Staff files and training records demonstrated that orientation and mandatory training includes emergency and disaster procedures, and fire safety. Emergency procedures and training, consider the needs of all residents, including those with ORA. An approved fire evacuation plan was sighted. Interviews with staff and review of documentation confirmed that fire drills are conducted at least six-monthly. There is a sprinkler system installed throughout the facility and exit signage displayed. Staff interviews, and training records confirm that fire wardens received warden training.</p> <p>The staff competency register evidenced that there is a system to ensure staff maintain first aid currency. In addition to all RNs, two other staff and all activities staff held current first aid certificates.</p> <p>The facility has supplies to sustain staff and residents in an emergency situation. Alternative energy and utility sources are available in the event of the main supplies failing. These include: a barbecue and gas for cooking; emergency lighting; and enough food, water, dressings and continence supplies. The service's emergency plan includes considerations of all levels of resident needs.</p> <p>All handbasins used for hand washing, including those in residents' rooms, have access to flowing soap and paper towels. These were observed to be used correctly by staff and visitors.</p> <p>Call bells are available to summon assistance in all resident rooms and bathrooms. Call bells are checked monthly by the maintenance person. Observation and resident interviews confirmed that call bells are answered promptly.</p> <p>Security systems are in place to ensure the protection and safety of residents, visitors and staff. These include visitors signing in and out of the building and the facility being locked in the evenings with restricted entry after hours.</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>All residents' rooms and communal areas accessed by residents have safe ventilation and at least one external window providing natural light. Resident areas in the facility are heated by under floor heating in the winter. The environment in resident areas was noted to be maintained at a satisfactory temperature. This was confirmed in interviews with staff and residents. Systems are in place to obtain feedback on the comfort and temperature of the environment.</p> <p>The facility has one designated external smoking area for residents who smoke.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment,</p>	<p>FA</p>	<p>Ultimate Care Kensington Court provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an infection prevention and control programme. An RN is the infection control nurse (ICN) and has access to external specialist advice from the DHB ICN. A</p>

<p>which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>documented role description for the ICN, including role and responsibilities, is in place.</p> <p>The infection control programme is appropriate for the size and complexity of the service. The infection prevention and control programme is reviewed annually. Staff are made aware of new infections through daily handovers on each shift, progress notes and clinical records. There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff, residents, and visitors to use.</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 ICN is responsible for implementing the infection prevention and control programme and is supported by the CSM. There is an infection control committee which is made up of staff members from each work area. The ICN has completed training for the role through Ministry of Health (MOH) online training course.</p> <p>The FM stated that there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the facility's quality meetings. The ICN has access to all relevant resident data to undertake surveillance, internal audits, and investigations. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>Ultimate Care Group has documented policies and procedures in place that reflect current best practice relating to infection prevention and control.</p> <p>Staff observed were complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all</p>	<p>FA</p>	<p>All staff attend infection prevention and control training. Staff education on infection prevention and control is provided at orientation and at the quality meetings. Health care assistants and RNs receive further training at their UCG study days and from external infection control specialists. Records of attendance are maintained. Staff interviewed confirmed that education on infection prevention and</p>

<p>service providers, support staff, and consumers.</p>		<p>control is provided.</p> <p>Education with residents occurs at the resident meetings and on a one-to-one basis and includes reminders about hand washing, remaining in their room if they are unwell, increasing fluids during hot weather and Covid-19. There was information regarding infection prevention and Covid-19 displayed on the notice boards. Staff receive notifications and updates about infection control via the electronic system, noticeboards, meetings and at handovers.</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>Ultimate Care Group surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal audits are completed.</p> <p>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. Family are updated by phone, email or text if required.</p> <p>Surveillance data is collected in the clinical areas and collated monthly and forwarded to the UCG national office for benchmarking. Information following monthly infection data collection and benchmarking is provided to staff through staff meetings, on the staff notice board and via the electronic system.</p> <p>There have been no outbreaks since the previous audit.</p> <p>Covid-19 information is available to all visitors to the facility. Ultimate Care Group information including MOH information was available on site. There are adequate infection prevention and control resources available should a resident infection or outbreak occur. There is an antimicrobial use policy.</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>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 the CSM, who provides support and oversight for enabler and restraint management in the facility. The CSM is conversant with restraint policies and procedures.</p> <p>On the days of the audit, no residents were using restraints or enablers.</p> <p>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. A review of restraint and enabler use is completed and discussed at all quality and clinical meetings.</p>

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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Facility meetings sighted are conducted as per schedule and cover: staff and quality; health and safety; residents and family’ meetings; and infection control and restraint. Review of meeting minutes showed that quality improvement information is shared with staff through the meetings and that minutes are made available for staff. Meeting minutes reflected detailed discussion of quality issues and indicators. However, they did not consistently record: the person responsible for implementing the quality improvements or the corrective actions; the timeframes involved; and the results of the actions’ follow up or sign off.</p> <p>Review of signing sheets signed by staff evidenced that staff are alerted of new or revised policies. Staff interviews confirmed that staff meetings are used to inform staff of changes to policies and procedures. However, staff meeting minutes did not always reflect the discussion of policies that occurred.</p> <p>Staff interviews and incident documentation on the electronic</p>	<p>Not all aspects of the quality management processes are documented when implemented.</p> <p>(i) Responsibilities, timeframes and sign-off for quality actions were not always documented in meeting minutes.</p> <p>(ii) Staff meeting</p>	<p>Ensure that:</p> <p>(i) All meeting minutes show responsibilities, timeframes and sign-off for quality and corrective actions.</p> <p>(ii) All quality items on the staff meeting agenda are recorded in the meeting</p>

		reporting system evidenced that resident incidents were reported promptly and managed, with documentation of corrective actions undertaken. However, five of eight incidents reviewed did not evidence sign off when closed.	minutes did not always document quality discussions that were conducted. (iii) Not all incidents reports had documented evidence of close-out when completed.	minutes. (iii) Incidents reports evidence sign off when completed. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	An annual education plan organises the minimum regulatory eight hours of professional development for nurses and other clinical, as well as non-clinical staff. Seven of eight files reviewed were for staff who had been employed for greater than one year. None of these staff had completed a performance appraisal within the preceding 12 months.	Annual performance appraisals are overdue for completion.	Ensure all staff undergo an annual performance appraisal. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	All medications are stored correctly as per UCG policy. Regular medications are delivered to the facility monthly. Medications received are required to be checked by an RN on delivery and the check recorded on the electronic system prior to administration. However, a sample of 16 medication files reviewed evidenced that: 15 out of 16 files had no recorded check for the medications delivered in February prior to administration; 12 out of 16 medication files had no recorded check of medications delivered in January.	Not all medications received from pharmacy were checked against the medication profile prior to administration.	Ensure that all medications received from pharmacy are checked before administration and the check is recorded. 60 days
Criterion 1.3.12.5 The facilitation of safe self-	PA Moderate	There were two residents self-administering medication for whom competency to self-administer had recently been approved by the GP, and documented. However there was no system in place for	Self-administration of PRN medications	Ensure that self-administration

administration of medicines by consumers where appropriate.		<p>recording the PRN medications which had been self-administered.</p> <p>Another resident interviewed indicated that they were self-administering eyedrops. The GP had been requested to complete a competency assessment for this resident at the time of audit; however, had not yet done so.</p>	is not consistently recorded, and competency assessments are not always in place for residents who self-administer medications.	<p>of medications is carried out in accordance with policy.</p> <p>60 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 Low	Initial care plans sighted were completed within 24 hours of admission. However, five out of eight files reviewed did not have a long-term care plan completed within three weeks of the resident's admission.	Long-term care plans are not consistently developed within the first three weeks after admission to the facility.	<p>Ensure long-term care plans are completed within the required timeframes.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.