

The Ultimate Care Group Limited - Ultimate Care Ranburn

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 Ranburn
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 30 March 2021 End date: 31 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:	67

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

The Ultimate Care Group Limited - Ultimate Care Ranburn provides rest home, hospital level care and dementia care for up to 71 residents. There were 67 residents at the facility on the first day of the audit.

This surveillance audit was conducted against a subset of the Health and Disability Services Standards and the service contract 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 general practitioner.

The area requiring improvement at the last certification audit relating to hazardous substances' management is now closed.

Areas identified as requiring improvement at this audit relate to adverse event documentation, 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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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights is made available to residents and family on the resident's admission and is available at the facility.

Interviews with residents, family and the general practitioner confirmed that the environment is conducive to communication, including open communication of any issues, and that staff are respectful of residents' needs.

Formal interpreting services are accessible if required.

There is a documented complaints management system that meets the requirements of Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. A current complaints register is maintained. Complaints are investigated and documented, with corrective actions implemented where required.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Ultimate Care Group Limited is the governing body responsible for the services provided at Ultimate Care Ranburn.

Ultimate Care Ranburn has current business plan and quality and risk management plan in place. The plans include the organisation's mission statement and values.

The service implements Ultimate Care Group Limited's quality and risk management system that supports the continuous quality improvement of clinical care and service delivery at the facility. Regular reports to the national support office are conducted.

The facility is managed by a facility manager who is supported in their role by a clinical services manager. The facility management team is supported by a regional clinical quality manager and a regional operations manager.

The quality and risk management systems include ongoing collection and analysis of quality improvement data. An internal audit programme is documented and implemented. Corrective action plans are documented from quality activities, with evidence of resolution of issues or follow up. Current policies and procedures support service delivery and are reviewed regularly.

Adverse events are documented. Actual and potential risks, including health and safety risks, are identified and mitigated.

Newly recruited staff undertake orientation appropriate to their role. Practising certificates for staff and contractors who require them are validated annually. Individual performance reviews take place annually and help identify training needs. A system is implemented to provide ongoing training that supports safe service delivery.

Staffing rosters meet contract requirements. Staffing levels are adequate to provide the required levels of services to residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Registered nurses assess residents on admission. The initial care plan guides care and service provision during the first three weeks after admission.

The interRAI assessments are used to identify residents' needs; these were 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 using an electronic system and are implemented within the required timeframes. Residents and their relatives are involved in the care planning process and notified regarding any changes in a resident's health status.

Handovers between shifts guide continuity of care and teamwork is encouraged.

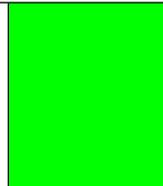
The activity programme is overseen by a diversional therapist. The programme provides residents with a variety of individual and group activities and maintains their links with the community. The service uses its facility van for outings in the community.

An electronic medication management system is in place. Registered nurses and health care assistants who administer medications have completed current medication competency requirements.

The food service meets the nutritional needs of the residents. All meals are prepared on-site. The service has a current food control certificate. Kitchen staff have food safety qualifications.

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.



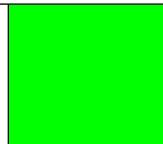
Standards applicable to this service fully attained.

A current building warrant of fitness is displayed.

There are implemented systems and processes for the safe management of hazardous waste and substances.

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 prevention and control nurse is a registered nurse. Infection data is collated, analysed and trended. Monthly surveillance data is reported to staff and to Ultimate Care Group Limited national office. There has been one outbreak since the previous audit which was managed in a timely manner.

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	13	0	0	4	0	0
Criteria	0	36	0	0	5	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The FM is responsible for the complaints' management. A sighted up-to-date complaints register is in place alongside collated evidence relating to each lodged complaint. Complaints since that last audit reviewed indicated that each complaint was acknowledged in writing to the complainant in the required timeframe, and that the actions undertaken for the complaint resolution were also communicated to the complainant in a timely manner. Complaints are managed in line with Right 10 of the Code.</p> <p>Residents and family interviewed reported that they feel free to raise and discuss concerns and issues with the facility, and that they are aware of the process to make a complaint. They stated that any issues raised were responded to by management in a timely manner. Residents and family had an understanding of their rights to advocacy, and how to access advocacy services, particularly in relation to the complaints process.</p> <p>There has been one complaint through the Health and Disability Commissioner (HDC). Sighted correspondence indicated that requested information had been sent to the HDC and the complaint had been closed. There were no other complaints to external agencies.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>Open disclosure policy and processes ensure open disclosure is practiced when required. The patient information folder provided to patients and their family on admission includes the organisation's open disclosure policy.</p> <p>Adverse events, where a resident has suffered unintended harm while receiving care, are documented, investigated</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>and communicated in an open disclosure manner. Incident documentation reviewed demonstrated that residents and family were informed if a resident had an accident/incident; a change in health; or a change in needs. Family and residents' interviews confirmed this occurs.</p> <p>Residents' meetings provide residents with an opportunity to provide feedback or to make suggestions on the service. Minutes from the residents' meetings evidenced that a range of subjects and issues are discussed, including but not limited to: activities; food service; laundry; maintenance; facility events and changes; resident surveys' results and presentations on aspects of the Code of Health and Disability Services Consumers' Rights (the Code). There was documented evidence that issues or concerns raised at the residents' meetings were responded to by management. Residents and family are provided with a facility newsletter on a regular basis.</p> <p>There are policies to ensure that information is supplied in a way that is appropriate for the resident and/or their family. Staff are guided by policy to ensure that residents who do not use English as their first language are offered interpreting services. The facility manager (FM) interview confirmed that there were two residents at the facility at the time of the audit, for whom interpretation was facilitated. For one resident, this included the use of interpretation cards and for the other family assisted when required, as requested by the resident.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The organisation has a documented vision, focus areas and values in place. The values are communicated to residents and family through the facility's information pack provided to residents and their family on admission.</p> <p>Ultimate Care Ranburn is part of the Ultimate Care Group (UCG). Communication between the management of the facility and the UCG executive management occurs at least monthly. The FM reported that regular contact with the regional manager occurs. The facility completes ongoing electronic reporting that provide the UCG executive management team with information on progress against identified indicators. Sighted monthly reports to the regional manager and national office evidenced that the service's performance is reported through: financial performance; occupancy; emerging risks and staffing; and through clinical indicators, such as but not limited to accidents/incidents, medication errors and infections.</p> <p>The service is managed by a FM who has been in the role over two years and attends relevant training and education related to aged residential care and management. Responsibilities and accountabilities of the FM role are defined in a job description and individual employment agreement. Interview with the FM confirmed knowledge of the sector, regulatory and reporting requirements. The UCG FMs across the region meet on a regular basis to discuss trends, issues and share ideas.</p> <p>The clinical services manager (CSM) has also been in the role over two years. They are a registered nurse (RN) with aged residential care experience.</p> <p>The facility is certified to provide rest home and hospital care services for up to 71 residents, with 67 beds occupied at the time of the audit. The facility has 26 rest home only beds, 21 hospital only beds, 6 dual purpose beds and 18 dementia beds. Occupancy included: 24 residents requiring rest home level care, 26 residents requiring hospital</p>

		<p>level care, and 17 residents requiring dementia level care.</p> <p>The facility holds contracts with the DHB for aged related residential care (ARRC); long-term chronic health conditions; and respite care.</p> <p>The facility had no residents with occupational right agreement.</p> <p>Adjoining the facility are 10 independent living villas.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Documented and implemented UCG quality and risk management plan is accessed by staff to guide service delivery, improve quality, monitor compliance and manage risk. The quality plan is reviewed annually by UCG.</p> <p>Documented policies and procedures align with the Health and Disability Services Standards and reflect accepted good practice guidelines. The UCG management reviews all policies with input from relevant personnel. Staff have electronic access via the UCG intranet. New and revised policies are presented to staff, which was verified by staff interviewed.</p> <p>The quality 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. Interviews with managers and documents reviewed confirmed that an annual internal audit programme is implemented. All aspects of quality improvement, risk management and clinical indicators are discussed at monthly staff meetings. Staff interviews, and meeting minutes confirmed that staff are kept informed of quality activities, and that quality data and corrective actions are developed, implemented and discussed at staff meetings.</p> <p>Residents' meeting minutes demonstrated that residents' feedback received during meetings inform the development and implementation of quality improvement initiatives and changes to service. Interviews with residents and family confirmed that residents have input into quality improvements and are satisfied with the changes introduced. Satisfaction surveys for residents and family are completed as part of the annual internal audit programme. Surveys reviewed evidenced high level of satisfaction with the services provided. There was evidence that corrective actions were developed and implemented for opportunities for improvement arising from resident satisfaction surveys.</p> <p>Health and safety policies and procedures are documented along with a hazard management programme. Staff interviews confirmed an awareness of health and safety processes and their responsibilities to report hazards, accidents and incidents promptly. Review of identification forms completed when a hazard is identified established that hazards are addressed, and risks minimised. A current hazard register is available.</p>
<p>Standard 1.2.4: Adverse Event</p>	PA	<p>The management team is aware of situations which are required to be reported to statutory authorities, including: unexpected deaths; police involvement; sentinel events; infectious disease outbreaks and changes in key</p>

<p>Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>Moderate</p>	<p>management roles. These are reported to the appropriate authority via the UCG support office. Notifications to HealthCERT under Section 31 were noted for a stage four pressure injury and a fall resulting in the subsequent death of a resident. A potential norovirus outbreak was reported to Public Health and the district health board (DHB) and previous inconsistent general practitioner (GP) coverage was reported to the DHB.</p> <p>Staff interviewed understood the adverse event reporting process and their obligation to document all untoward events. A review of documentation confirmed that staff document adverse, unplanned or untoward events on accident/incident forms which are signed off by the FM.</p> <p>Review of staff training records confirmed that staff receive orientation and ongoing education on accident/incident reporting processes.</p> <p>Accident/incident reports reviewed and family and residents interviewed evidenced that where appropriate, the resident's family and GP had been notified of the incident. The events' records demonstrated that assessments and action plans had been documented for each event. However, responses to unwitnessed falls did not always evidence best practice.</p> <p>Accident/incidents are graphed, trends analysed and fed back to staff at meetings. A sample of recorded accidents/incidents evidenced they were predominantly falls and wounds.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position are documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; police vetting; identification verification; a position specific job description; a signed employment agreement and where required a current work visa.</p> <p>Professional qualifications are validated and current certificates were evidenced for all staff and contractors that required them. There are systems in place to ensure that annual practising certificates and practitioners' certificates are current for those who required them. New staff receive an orientation/induction programme that covers the essential components of the services provided. Care givers (CG) and domestic staff interviews stated that they are buddied with an experienced staff member until they demonstrate competency on specific tasks.</p> <p>The organisation has a documented annual education and training module/schedule that includes topics relevant to all services, and to all levels of care provided. The CSM and four of seven other RNs have completed interRAI assessment training and competencies. Care staff working in the dementia units have completed, or are in the process of completing New Zealand Qualifications Authority (NZQA) Careerforce training, The RNs have completed dementia training through the DHB. Care staff complete annual competencies, for example: moving and handling; hoist use; hand washing; and medication management.</p> <p>Attendance records evidenced that staff receive ongoing education which is relevant to the services delivered.</p>

		Interviews and training records reviewed confirmed that all staff, including RNs, undertake at least eight hours of relevant education and training hours per year.
<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>The organisation's staffing and skill mix policy and documented formula provide guidance to ensure staffing levels within the facility; meet the needs of residents' and adhere to the minimum requirements of the DHB contract. Staffing levels are reviewed to accommodate anticipated workloads identified numbers of residents, and their acuity.</p> <p>There are 7 RNs and 32 CGs available to maintain the rosters for the provision of care. Interview with the FM identified that agency RNs are required at times. The FM and CSM work on morning duties on week days. On the morning shift there are two CGs in the hospital, three in the rest home and three in the dementia unit. Afternoon shifts have two CGs in the hospital, two in the rest home and two in the dementia units. On night shifts there are three CGs for the whole facility. There is at least one RN on each shift, seven days per week. The facility aims to have two RNs on each morning and afternoon shift; however, there had been six instances in which week day morning shifts over four weeks only had one RN rostered. These instances had been managed by rostering the one RN on the morning shift with the support of the CSM to manage the clinical cares, and the support of a supernumerary senior CG in the clinical team. A new RN has been recruited to provide additional support to the roster. Rosters sighted reflected adequate staffing levels to meet current resident acuity and bed occupancy. Residents with complex cares are in rooms situated close to the nurses' station.</p> <p>The FM and CSM share the on call after hours, seven days a week. Interview with the management team advised that the regional manager is available 24/7 to support the facility with emergency matters.</p> <p>Observation of service delivery confirmed that residents' needs were being met in a timely manner. Residents and family interviewed stated that although staff were busy at times, the residents' care needs were met. Staff confirmed that they were able to complete their scheduled tasks and resident cares each shift.</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</p>	PA Moderate	<p>A current medication management policy identifies all aspects of medicine management in line with the relevant legislation and guidelines.</p> <p>An electronic system for medicine management was observed on the day of audit. Prescribing practices in line with legislation, protocols and guidelines were observed. The required three-monthly reviews of prescribed medication 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 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. General practitioner approved standing orders are used at the facility.</p>

<p>guidelines.</p>		<p>Review of the two medication fridges evidenced that the service does not store or hold vaccines, and interviews with the RN confirmed this. The medication refrigerator temperatures were monitored; however, monitoring was not consistently carried out as per policy. The temperature of the two medication rooms is recorded daily, however both medication rooms have had temperatures during the past three months outside the required range. There was no documented corrective action taken to address temperatures outside the normal range.</p> <p>Medications administered by staff 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.</p> <p>The staff were observed administering medication in a manner that complied with the medicine administration policies and procedures. At interview, they demonstrated knowledge and understanding of their roles and responsibilities relating to each stage of medication management. The RNs oversee the use of all pro re nata (PRN) medicines, and documentation made regarding effectiveness of PRN medication was sighted on the electronic medication record. Current medication competencies were evident in staff files.</p> <p>There were two residents self-administering medication during the on-site audit. However, required GP approvals had not been consistently completed, and no lockable storage had been provided for the self-administered medication.</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 expires June 2021. Food management training and certificates for cooks and kitchen staff were sighted.</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 were implemented.</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 when dietary profiles are reviewed six-monthly. 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 sufficient time to eat their meal and assistance was provided when necessary. There were sufficient staff to ensure appropriate assistance was available at meal times. 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 the time of the audit complies with current legislation and guidelines. The cook is responsible for purchasing the food to meet the</p>

		requirements of the menu plans. Food is stored appropriately in fridges, freezers 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 observed dry stock containers were labelled and dated.
<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>	PA Moderate	<p>Long-term care plans are completed by the RN and based on assessed needs, desired outcomes and goals of residents. However, not all long-term care plans contained interventions for management of needs identified during the assessment process. Short-term care plans were not in place for all acute problems.</p> <p>The GP interviewed visits the facility weekly and meets with the clinical services manager virtually once a week. They verified that medical input is sought in a timely manner and medical orders are followed.</p> <p>Staff interviews confirmed that they are familiar with the needs of residents and that they have access to the equipment, 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. 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.</p> <p>The nursing progress notes are recorded and maintained. Family communication is recorded in the progress notes.</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>	PA Moderate	<p>The residents' activities programme is overseen by a diversional therapist. In the rest home activities are provided from 7:30am to 3:30pm, Monday to Friday. In the hospital activities are provided for four hours a day from Tuesday to Saturday. On Saturday and Sunday, a range of self-directed activities are available for residents to access, which include puzzles, DVDs and quizzes. In the dementia wing activities are provided five days a week from 7:30am to 3:00pm Tuesday to Saturday. The activities programme is displayed on the resident noticeboards. The activities programme provides variety in the content and includes a range of activities which incorporate education, leisure, cultural, spiritual and community events. Regular van outings into the community are arranged.</p> <p>The residents' activities assessments are completed within three weeks of the residents' admission to the facility by the diversional therapist in conjunction with the admitting RN. Information on residents' interests, family 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 as the care plans and are part of the formal six-monthly multidisciplinary review process. However, a description of the activities that meet the resident's assessed needs in relation to individual activities over a 24-hour period was not documented for all residents living in the dementia wing.</p> <p>The residents and their family reported satisfaction with the activities provided. Over the course of the audit, residents were observed engaging in a variety of activities.</p>

<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 of status 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 and 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.</p> <p>Residents and family interviewed confirmed involvement in the evaluation process and any resulting changes. Contact with family was verified in the resident's records and documented in the individual resident files reviewed.</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>There are documented and implemented processes for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that comply with current legislation and territorial authority requirements.</p> <p>Chemicals were observed to be stored safely in the laundry, cleaning and maintenance areas, with signage to remind staff to ensure that these areas are locked when not in use. Personal protective equipment (PPE) is provided and appropriate to the risks involved when handling waste or hazardous substances. Staff were observed to use PPE correctly and where required.</p> <p>The finding at the previous audit relating to storage of hazardous substances has been closed.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	FA	<p>The building warrant of fitness is current and displayed at the facility. There have been no alterations to the facility since the previous audit.</p>

for their purpose.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Ultimate Care Group surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. The infection control nurse (ICN) is an RN. The ICN is responsible for infection prevention and control in the facility and has a signed position description, which includes requirements of the role and responsibilities.</p> <p>Internal infection prevention and control audits are completed (sighted). Infection data is collated monthly by the CSM and is submitted to UCG national office. Monthly surveillance data is collated and analysed to identify any trends, possible aetiology and any required actions. This data is reported at the clinical and staff meetings.</p> <p>Interview with the CSM confirmed there has been one outbreak in January 2020. Documentation reviewed confirmed that this had been managed and reported as required.</p> <p>Covid-19 information is available to all visitors to the facility. Ultimate Care Group information including Ministry of Health information was available on site. Infection prevention and control resources were 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>	FA	<p>Policies and procedures meet the requirements of restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. An RN is the restraint coordinator and has undertaken training for this role. On the day of audit there were no residents using restraints or enablers. Restraint is used as the last resort after all other alternatives have been tried. Use of enablers is voluntary. This was evident from documentation reviewed and staff interviews. Restraint minimisation and safe practice education is provided to all staff at orientation/induction to the service and ongoing education is provided to staff annually.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA</p> <p>Moderate</p>	<p>Interviews with care staff demonstrated their understanding of the reporting and escalation process. Immediate responses to events are documented. However, 11 of 12 unwitnessed falls, neurological observations in response to unwitnessed falls were not fully completed per policy.</p>	<p>Residents did not consistently have a neurological observations undertaken following an unwitnessed fall, as per the best practice requirements outlined in policy.</p>	<p>Ensure a neurological observations are conducted and documented post unwitnessed falls as per the best practice requirements outlined in policy.</p> <p>30 days</p>

<p>Criterion 1.3.12.1</p> <p>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.</p>	<p>PA Moderate</p>	<p>Medications administered by clinical staff are securely stored in locked rooms. Medications that require refrigeration are stored in fridges. There are documented processes in place to monitor the medication rooms' and fridges' temperatures on a regular basis, which comply with good practice requirements and guidelines.</p> <p>However, the temperature of the medication fridges were not recorded daily as per UCG policy. In the past month, recordings had not been completed on 16 out of 30 days.</p> <p>The hospital and rest home medication room temperatures are recorded daily. However, sample record of past three months demonstrated that when the temperatures had not been within the normal range, corrective actions had not been taken or documented. The temperatures in both rooms have been above the normal range more than 50% of the time in January, February and March. A heat pump was installed in the hospital medication room the week before the audit to regulate temperature, but not in the rest home medication room.</p>	<p>i) Medication fridges' temperatures are not consistently recorded.</p> <p>ii) Corrective actions have not been recorded or fully actioned when the medication rooms' temperatures have been above the normal range.</p>	<p>i) Ensure that the temperature of the medication fridges is recorded daily.</p> <p>ii) Ensure that a corrective action is put into place and documented when the temperature of the medication room is above the normal range.</p> <p>60 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Moderate</p>	<p>Two residents are self-administering medication in the rest home. The GP had approved medication self-administration for one resident; however, there was no approval in place for the second resident. There had been no ongoing self-administering medication competency checking for either resident. No lockable storage of medication was provided for the self-medicated medicines.</p>	<p>i) Self-administration of medication competency checks are not carried out in accordance as per regulatory requirements.</p> <p>ii) Secure storage is not provided for residents self-administering medication.</p>	<p>Ensure that self-administration of medication is carried out as per regulatory requirements.</p> <p>60 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>The progress notes of residents with short term problems contained information relating to the acute situation. However, review of sampled records for residents who experienced a short-term problem showed that in five out of six instances, there was no short-term care plan developed to guide resident care in response to the acute situation (eg, infections).</p> <p>All residents had a long-term care plan developed by an RN with input from residents and family as appropriate. In three of six files reviewed, long-term care plans did not contain interventions for continuous needs identified by the assessment process, which included high risk of pressure injuries, falls risks and challenging behaviours. Two files reviewed of residents living in the dementia wing did not include interventions for managing challenging behaviour.</p>	<p>i) Short-term care plans were not always in place for residents with acute problems.</p> <p>ii) Long-term planned interventions did not consistently reflect all residents' assessed needs.</p>	<p>i) Ensure that a short-term care plan is in place for all residents with acute problems.</p> <p>ii) Ensure long-term care plans include interventions that reflect all residents' identified needs.</p> <p>60 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Moderate</p>	<p>Activities for residents living in the dementia wing are provided five days a week from 7:30am to 3:00pm. However, resident care plans did not contain interventions for challenging behaviour (refer 1.3.6.) or a description of the activities that meet the residents needs in relation to individual diversional, motivational and recreational therapy during the 24-hour period (ARCC E4.3).</p>	<p>Documentation of activities over a 24-hour period was not in place for all residents assessed as needing secure dementia care.</p>	<p>Ensure that all residents assessed as needing secure dementia care have their activity needs documented over a 24 hour period</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.