

The Ultimate Care Group Limited - Ultimate Care Churtonleigh

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 Churtonleigh	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 09 February 2022	End date: 10 February 2022
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:	32	

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 Churtonleigh is part of the Ultimate Care Group Limited. The facility is certified to provide services for up to 44 people requiring rest home or hospital level services, and managed by a facility manager and a clinical services manager. Occupancy on the first day of this audit was 32 residents. 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 general practitioner.

Areas identified as requiring improvement relate to: quality management systems, staffing, medication management, and environmental risks.

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.	Green	Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights and these are respected. Services are provided that support the residents' personal privacy, independence, individuality and dignity.

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

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Informed consent is practised, and written consent is gained when required.

Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse and neglect.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
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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 current business plan and quality and risk management 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 in the facility. A regional manager supports the facility's managers in their roles.

The quality and risk management systems are in place. Meetings are held that include reporting on various clinical indicators, quality and risk issues, and there is discussion of identified trends.

There are human resource policies and procedures, based on current good practice, that guide practice in relation to recruitment, orientation and management of staff. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review.

Systems are in place to ensure the secure management of resident and staff data.

Continuum of service delivery

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

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

Long term care plans are developed and implemented within the required timeframes. Residents' files reviewed demonstrated evaluations were completed six-monthly and when there is a change in the resident's condition. Residents and their relatives are notified regarding any changes in a resident's health status.

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

An electronic medication management system is in place. Medications are administered by the registered nurse and care givers who have completed current medication competency requirements.

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

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		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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There is a current building warrant of fitness. There is a reactive and preventative maintenance programme. External areas are accessible, and provide shade and seating. Residents' bedrooms are of an appropriate size for the safe use and manoeuvring of

mobility aids if required and allow for care to be provided. Lounges, dining rooms and sitting alcoves are available for residents and their visitors. Communal and individual spaces are maintained at a comfortable temperature.

A call bell system is available to allow residents to summon help when needed. Security systems are in place and staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills.

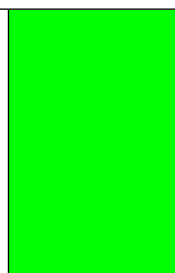
Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry and cleaning are undertaken onsite and evaluated for effectiveness.

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, there was one resident using a restraint and no residents using enablers. 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, and trended. Monthly surveillance data is reported to staff. There has been one outbreak 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	45	0	1	3	0	0
Criteria	0	97	0	1	3	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	25
Criteria	0	0	0	0	41

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>	<p>FA</p>	<p>Ultimate Care Churtonleigh 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>Staff training records and interviews with staff 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 evidence an understanding of their obligations. Evidence that the Code is implemented in their everyday practice includes but is not limited to: maintaining residents’ privacy; providing residents with choices; involving family and residents in decision making; and ensuring residents are able to practise their own personal values and beliefs.</p> <p>Resident and family interviews, and observation confirmed that services are provided in a manner that upholds resident dignity and maintains their privacy. Staff were observed to be respectful towards residents and their families and resident and family interviews</p>

		confirmed that they receive information relevant to their needs.
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>A consent policy is in place to ensure that a resident who is competent to consent to a treatment or procedure, has been given information to reach an independent decision. The policy includes a definition of consent and how this will be facilitated and obtained.</p> <p>Observations evidenced that residents or their EPOA sign informed consents in line with legislation.</p> <p>All staff interviewed, including non-clinical staff, demonstrated they are cognisant of the procedures to uphold informed consent.</p> <p>The CSM stated that they discuss informed consent with residents and family during admission and care planning. This includes consent for resuscitation and advance directives. When required, advance care planning and EPOA are documented. File reviews and staff interviews demonstrated that advance directives, resuscitation orders and EPOA were completed for residents in accordance with policy.</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>	FA	<p>There is an advocacy policy and procedure to ensure that residents and their families have a right to be represented and express views or concerns about their situation. It includes making them aware of the availability of advocacy services and supports access to advocacy services.</p> <p>Information regarding the availability of the Nationwide Health and Disability Advocacy Service is included in the information pack provided to residents and family on admission. The complaints policy also includes making residents aware of their right to advocacy when making a complaint.</p> <p>Interviews with residents and family confirmed that they are aware of the right to advocacy.</p> <p>Advocacy services can be sought when required from a local advocate 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</p>	FA	<p>Observations and resident and staff interviews confirmed that residents may have access to visitors of their choice. There are areas where a resident and family can meet in private. Interviews with</p>

<p>their community.</p>		<p>residents and families, as well as observation, confirmed that families are welcome in the facility and were free to visit at any time (covid-19 regulations permitting).</p> <p>Interview with residents and staff confirmed that residents are free to leave the facility and do so to be involved in such events such as visiting family and shopping trips. 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, and upheld.</p>	<p>FA</p>	<p>There is an implemented complaints policy and procedure that is in line with the Code. The resident welcome pack outlines the Code and includes information regarding the facility's complaint procedure. The complaint form was readily available within the facility. The resident and family interviews confirmed that the complaints process is explained on entry to the facility. The FM interview and resident meeting minutes confirm that the complaints process is explained and discussed at resident meetings.</p> <p>A complaints register is in place and the register includes: the date the complaint is received and acknowledged; the source of the complaint; a description of the complaint; the investigation; changes implemented and the date the complaint is resolved.</p> <p>The 2021 register documented five complaints. All complaints reviewed indicated that complaints are investigated promptly, and issues are resolved in a timely manner.</p> <p>The FM is responsible for managing complaints. Resident and family interviews confirmed that they are aware of a complaints process and would feel comfortable to make a complaint if needed.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Information on the Code and Nationwide Health and Disability Advocacy Services is available and displayed in the facility. The facility manager (FM) or clinical services manager explains information provided to residents and families in the pre-admission and admission pack, such as the Code, advocacy services and the complaints process during the admission interview to ensure understanding,</p> <p>Resident interviews confirmed they understand their rights and 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>	<p>FA</p>	<p>The organisation has policies and procedures that are aligned to the requirements of the Privacy Act and Health Information Privacy Code to ensure that a resident's right to privacy and dignity is upheld.</p> <p>Staff interviews, and observation confirmed that resident confidentiality was maintained. Resident and family members' interviews confirmed that resident privacy was respected. Staff were observed to knock on bedroom doors prior to entry, ensured that doors were shut when personal cares were being provided and residents were suitably attired and covered when taken to the bathrooms. Resident interviews confirmed that resident privacy was respected.</p> <p>The organisation has a policy on sexuality and intimacy that provides guidelines for staff in managing expressions of sexuality and defines appropriate expressions of sexuality. Resident and family interviews and observation 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 staff, resident and family interviews confirmed that individual cultural, religious, social preferences, values and beliefs were identified, documented and upheld.</p> <p>There is an abuse and neglect policy that 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. There were no documented incidents of abuse or neglect and this was confirmed in staff, resident and family interviews.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Ultimate Care (UC) has a Māori health plan that identifies how the facility will respond to Māori cultural needs and beliefs in relation to illness. Staff receive training in 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 information obtained in assessments relating to cultural needs was documented in care planning.</p> <p>Staff interviews described awareness of the individual needs of the</p>

		Māori resident and support for staff for providing culturally appropriate care, for Māori residents. The whānau for the current resident are a source for staff support, other support would be sourced externally or through UC when required. Interviews also confirmed awareness of the importance of involving whānau in the delivery of care.
<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, spiritual values, and beliefs, as well as spiritual and cultural preferences such as church services. This information informs activities that are tailored to meet identified needs and preferences.</p> <p>For residents who wish to attend, there are regular church services each month.</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 professional boundaries their obligation to report any evidence of discrimination, abuse and neglect, harassment and exploitation.</p> <p>Staff signed agreements, defining the standards of conduct, as part of their employment documentation.</p> <p>Staff interviews confirmed their understanding of professional boundaries relevant to their respective roles. Resident interviews confirmed that staff acted professionally and maintained appropriate professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The facility implements UC policies and procedures. These are based on good practice and current legislation and guidelines. Policies align with the Health and Disability Services Standards and ensure safe, current evidence-based practice.</p> <p>The annual training programme provided to all staff includes: the implementation of policy and procedures, good practice and service</p>

		<p>delivery.</p> <p>Clinical consultation and expertise are available through UC clinical leadership.</p> <p>Staff and resident interviews, progress notes in residents' file notes 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>	FA	<p>The organisation has an open disclosure policy that promotes a transparent, consistent approach to full and open disclosure where there is a harmful event during the course of resident care or a change in resident's condition. Completed accident/incident forms, clinical records and resident and family interviews demonstrated that open disclosure is implemented, and enduring power of attorney (EPOA) and next-of-kin are informed when required.</p> <p>Meeting minutes and interviews with residents confirmed that they were able to participate in residents' meetings and discussions. The facility also provides family and residents with access to a newsletter and residents' meeting minutes, that provide updates of activities and events within the facility.</p> <p>There were no residents who required the services of an interpreter. Staff interviews advised that interpreter services would be sourced through the local district health board, if required.</p> <p>Resident interviews described staff as being approachable and responsive and they were satisfied with explanations and information 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>	FA	<p>The UC Churtonleigh facility is part of Ultimate Care Group (UCG) with the executive team providing direction to the service. The FM reports to a regional manager who oversees the facility's quality and operational performance. The regional manager holds a weekly video meeting with all of the FMs and clinical services managers in the region and visits the facility in person at least three-monthly, in addition to providing ongoing remote support. The regional manager provided on-site support to the facility during this audit.</p>

		<p>The organisation has a documented vision, mission and values statement. The organisation values were displayed in the facility and in information available to residents and family.</p> <p>The FM is a non-clinical experienced manager with qualifications in health and safety management who has been in the role for eight months. The clinical services manager has held this position for over five months and has previous experience in an acting clinical services manager role and RN at the facility. The clinical services manager has a current RN practicing certificate. Both managers have completed at least eight hours educational training and UCG management orientation programs.</p> <p>The service provides rest home and hospital level care for up to 44 residents. Services are provided across two wings with two rest home premier rooms upstairs and all other beds are dual purpose. At the time of the audit, there were a total of 32 residents: 11 residents receiving hospital level care and 21 residents receiving rest home level care. Included in these numbers was one rest home resident on respite care. At the time of audit all residents were under the district health board aged related residential care agreement.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The FM advised that in the short absence of the FM, the clinical services manager would be responsible for the management of the facility. In the short absence of the clinical services manager, a senior RN would cover the clinical services manager's role. The regional manager would also provide support to staff during absences of the FM or clinical services manager.</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>	<p>PA Low</p>	<p>There are policies and procedures, and associated implementation systems to ensure that the facility meets accepted good practice and are adhering to relevant standards, including standards relating to the Health and Disability Services (Safety) Act 2001. Policies are regularly reviewed at head office level, and all are current. New policies or changes to policy are communicated to staff.</p> <p>There is an implemented annual schedule of internal audits. Areas of non-compliance from the internal audits include the implementation of a corrective action plan with sign-off by the FM when it is completed. However, analysis of trends and evaluation of outcomes requires</p>

		<p>improvement. The Ultimate Care Group has made improvements to the electronic system with regard to this, but these are not yet fully implemented.</p> <p>Since the last audit a new reporting tool called the 'manager's reflective report' has been developed and enacted to capture quality improvement initiatives as a result of internal audit findings. Quality improvement initiatives include the incorporation of improved clinical indicators into the everyday life of the facility.</p> <p>An annual resident and relative satisfaction survey was completed in 2021, with an average rating of 97% approval. Areas requiring corrective action include the residents' right to choose and meal satisfaction. These results have just been collated and a corrective action plan is being developed and actioned.</p> <p>The FM is the appointed health and safety officer, who is supported by the regional manager and facility health and safety team.</p> <p>Staff meetings (five various meetings; quality, health and safety, caregivers, RNs, infection control and prevention) that were all held monthly have been moved into a comprehensive once monthly meeting for all staff, with good staff attendance. These meetings include but are not limited to; quality; restraint; health and safety and infection control; care issues; staffing; maintenance; activities; cleaning and laundry; food service; accident/incidents reporting; staff education and competencies; updated policy and procedures; restraint; and internal audit results and associated corrective actions.</p> <p>Hazards are identified on hazard identification forms. The hazard register is relevant to the service and has been regularly reviewed and updated.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Senior staff 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, and the new clinical services manager, as well as three temporary clinical services managers during 2021. There is also ongoing Section 31 reporting throughout 2021-22 regarding the lack of RN cover for all shifts, which is now required to have fortnightly reports</p>

		<p>to the district health board.</p> <p>There is an electronic system to record and report all resident clinical incidents/accidents. The incident reporting system links to the quality management system. Review of incident reporting indicated that whenever possible families or emergency contacts are informed of unanticipated events and changes in a resident's clinical condition. The general practitioner (GP) was notified when required. Staff interviewed confirmed that clinical incidents/accidents are reported to the RN in charge in a timely manner.</p> <p>Review of the incidents outlined a robust process was in place to ensure appropriate changes were made in order to mitigate reoccurring events, for example resident falls.</p> <p>Clinical incidents/accidents reviewed evidenced documentation and evaluation by the clinical services manager. 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>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 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 includes: police vetting; references checks 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 and first aid certificates.</p> <p>Non-clinical staff include household and laundry personnel, a part time 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. Annual</p>

		<p>performance appraisals were completed for all staff requiring these and three monthly reviews had been carried out for newly appointed staff. Staff competencies and education scheduled are relevant to the needs of aged-care residents, including those receiving hospital level care.</p> <p>Three RNs (inclusive of the clinical services manager) are interRAI trained and caregivers complete Careerforce training in New Zealand Qualification Standards (NZQA) to level four.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Moderate</p>	<p>Ultimate Care Group Churtonleigh policy includes the rationale for staff roster and skill mix, inclusive of a FM's roster allocation tool to ensure staffing levels are maintained at a safe level. Interviews with residents, relatives and staff confirmed that staffing levels (inclusive of cleaning and laundry duties) are sufficient to meet the needs of residents when there is full staff available. Rosters reviewed evidenced that staff were replaced when sick by other staff members picking up extra shifts and with the use of agency staff when available, with some shifts left short. The clinical services manager covers registered nursing shifts when a senior caregiver is not available. Laundry and cleaning staff are rostered on for four hours seven days per week.</p> <p>The FM works 40 hours per week, Monday to Friday, and is available on call for any non-clinical emergency issues. The clinical services manager works 40 hours per week and is available on call for clinical support and as well, staff are supported by the Ultimate Care Group 504 on call clinical support helpline.</p> <p>Due to staff turnover and leave taken, the facility does not have full 24/7 RN cover for afternoon and night shifts. RNs are replaced on both afternoon and night shifts by senior caregivers who have a current first aid certificate and medication competencies. The FM with the assistance of head office human resources staff is currently advertising and recruiting for vacant positions.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Residents' records 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</p>

		<p>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 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 resident's 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. An information pack is provided to all residents and their families prior to admission. Review of residents' files confirmed entry to service processes are implemented, ensuring compliance with entry criteria.</p> <p>Residents and family members interviewed stated they were satisfied with the admission process and that it had been completed in a timely manner. Information about UC Churtonleigh had been made available to them. Residents' 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,</p>	FA	<p>Transition, exit, discharge, or transfer is managed in a planned and coordinated manner.</p> <p>Interviews with the clinical services manager and RN and review of</p>

<p>discharge, or transfer from services.</p>		<p>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>	<p>PA Moderate</p>	<p>A current medication management policy identifies all aspects of medicine management in line with relevant legislation and guidelines.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices are in line with legislation, protocols, and guidelines. The required three-monthly reviews by the GP were recorded electronically. Resident allergies and sensitivities are documented on the electronic medication chart and in the resident's electronic record.</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. There are no standing orders.</p> <p>Review of the medication fridge evidenced that the service does not store or hold vaccines and interview with the RN confirmed this. The medication refrigerator temperatures and medication room temperatures are monitored daily, however the medication room temperature is consistently above the required level.</p> <p>Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration. Weekly checks of medications and six monthly stocktakes are conducted in line with policy and legislation.</p> <p>The staff observed administering medication demonstrated knowledge and at interview demonstrated clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures. The RN oversees the use of all pro re nata (PRN) medicines and documentation made regarding effectiveness on the electronic medication record and in the progress notes was sighted. Current</p>

		<p>medication competencies were evident in staff files.</p> <p>There were no residents self-administering medication on the day of the audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The kitchen manager is responsible for the food services. The food service is in line with recognised nutritional guidelines for older people. All meals are prepared on site and served in the dining rooms or in the residents' 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 expiry date is June 2022. Food management training and certificates for cooks were sighted.</p> <p>Food temperatures are monitored appropriately and recorded. The kitchen staff have relevant 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 nutritional profiles are communicated to the kitchen staff and updated when a resident's dietary needs change. Diets are modified as needed and the kitchen manager at interview 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. Residents and families 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 comply with current legislation and guidelines. The cook is responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately in fridges and freezers. 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>
Standard 1.3.2: Declining Referral/Entry To Services	FA	The service has a process in place if resident's access is declined.

<p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>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 not within the scope of the service or if a bed was 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>	<p>FA</p>	<p>The initial nursing assessments which include: dietary needs; pressure injury; falls risk and social history are completed using the electronic system. Assessments reflect data from a range of sources, including: the resident; family/whānau; the GP and specialists.</p> <p>The initial care plan guides care for the first three weeks following the resident's admission. Registered nurses complete the interRAI assessment within the required timeframes. The LTCP is based on the interRAI assessment outcomes and the initial nursing assessments.</p> <p>Policies and protocols are in place to ensure continuity of service delivery.</p> <p>All residents under the aged related residential care agreement have current interRAI assessments completed by one of three trained interRAI assessors on site.</p> <p>Residents and family members confirmed involvement with the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Long-term care plans are developed from information gathered during the first three weeks following admission and from the interRAI assessment. All residents' files sampled had individualised long-term care plans with interventions to meet the needs of the residents. Care plans demonstrate service integration with clinical records, activities notes, and medical and allied health professionals' notes and letters.</p> <p>The activity care plan is completed by the diversional therapist within three weeks of admission.</p> <p>Short term care plans were evident in some resident files and addressed short term concerns for example infections and weight loss.</p> <p>Interviews with residents confirmed that the care provided met their needs. There was documented evidence that EPOA / whānau had been involved in the review of care plans.</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 the RN and based on assessed needs, desired outcomes, and goals of residents. Short-term care plans are in place for acute problems.</p> <p>The GP visits the facility weekly. Documentation and records reviewed were current. The GP interviewed stated that there was good communication with the service and that they were informed of concerns in a timely manner. The GP provides an after-hours service.</p> <p>A physiotherapist visits the facility weekly and reviews residents referred by the clinical services manager or RNs.</p> <p>There was evidence of wound care products available at the facility. The review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were taken where this was required. Where wounds required additional specialist input, this was initiated.</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. Staff receive handover at the beginning of their shift, this is managed using the electronic system with additional input from the RN as required.</p> <p>Family communication is recorded in the residents' files. The nursing progress notes are recorded and maintained.</p> <p>Monthly observations such as weight and blood pressure were completed and are up to date. Neurological observations are recorded following all unwitnessed falls in accordance with UCG policy and best practice.</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 and an activities officer (AO). Activities for the residents are provided five days a week, 10am to 3.30pm. The activities programme is displayed in the communal area and on the individual 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. Church services are held monthly. Regular van outings into the community are arranged.</p>

		<p>The residents' activities assessments are completed by the diversional therapist within three weeks of the residents' admission to the facility in conjunction with the admitting RN. Information on residents' interests, family and previous occupations is gathered during the interview with the resident and/or 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.</p> <p>There is evidence of resident and family/whānau participation. Regular resident meetings are held and include discussion around activities. The residents and their families reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging and enjoying 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>	<p>FA</p>	<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 desired goals and outcomes.</p> <p>The service develops short-term care plans for the management of short-term acute problems. If in place short-term care plans are reviewed weekly or more often as necessary and signed off when the problem is resolved.</p> <p>Contact with family was verified in the residents' records.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The service 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>	<p>FA</p>	<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 the mandatory training.</p> <p>Interviews and observations confirmed that there is enough PPE and equipment provided, such as aprons, gloves and masks. Interviews confirmed that the use of PPE is appropriate to the recognised risks. Observation confirmed that PPE was used in high-risk areas.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Moderate</p>	<p>A current building warrant of fitness is displayed 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 three days weekly, by the maintenance person and attended to as required. Interviews confirmed staff awareness of the processes 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. Staff interviews and documentation evidenced that those staff who drive the van have a current driver's licence and first</p>

		<p>aid certificate.</p> <p>Hot water temperatures are assayed monthly. However, issues with high temperatures are not addressed.</p> <p>All resident areas can be accessed with mobility aides. There are small accessible external courtyards and decks. All external decked areas have outdoor seating and shade and can be accessed freely by residents and their visitors. One area has two hazards with regard to safe mobility.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible showers, hand basins and toilets throughout the facility, with a combination of ensuite, 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; sufficient room; approved handrails; and other equipment to facilitate ease of mobility and to promote independence.</p> <p>Residents were observed being supported to access communal showers in a manner that was respectful and maintained the resident's dignity.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Residents have their own room, and each is of sufficient size to allow residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. All rooms have sufficient space to facilitate the use of a hoist. Observation and interviews with residents confirmed that there was enough space to accommodate: personal items; furniture; equipment and staff as required.</p> <p>Residents and their families can personalise the resident's room. Furniture in residents' rooms include residents' own personal pieces and memorabilia; is appropriate to the setting and is arranged in a manner that enables residents to mobilise freely.</p> <p>There are designated areas within the facility to store equipment such</p>

		as wheelchairs, walking frames, commodes and hoists, tidily.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are dining rooms and lounges at the facility and a central kitchen. There are a number of small nooks with seating. All internal communal areas have seating and external views. Areas can be easily accessed by residents, family and staff. There are areas that are available for residents to access with their visitors for privacy, if they wish. Observation and interviews with residents and family confirmed that residents can move freely around the facility and that the accommodation meets residents' needs.</p> <p>There are areas for storing activities equipment and resources. 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>	FA	<p>Laundry and cleaning services are provided seven days a week. Sampled rosters confirmed that cleaning and laundry duties are rostered part time each day, with caregivers on afternoon and night shifts completing the work, (refer to 1.2.8.1).</p> <p>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 families confirmed satisfaction with laundry services in interviews and in satisfaction surveys.</p> <p>One cleaner is on duty each day, for four hours seven days a week and cleaning duties and procedures are documented 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</p>

		cleaning equipment and chemicals. Household personnel interviewed are 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>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Staff files and training records demonstrated that orientation and mandatory training includes emergency and disaster procedures and fire safety. 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 and staff have undertaken fire 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, there two other staff and activities staff with current first aid certificates.</p> <p>The facility has sufficient 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 barbeque 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 need.</p> <p>All hand basins 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 afterhours.</p>
Standard 1.4.8: Natural Light, Ventilation, And Heating	FA	All residents' rooms and communal areas accessed by residents have safe ventilation and at least one external window providing natural

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>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 a one designated external smoking area for residents who smoked.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Ultimate Care Churtonleigh provides an environment that minimises the risk of infection to residents, staff, and visitors by implementing an infection prevention and control programme. A RN is the infection control nurse (ICN) and has completed training for the role. The ICN has access to external specialist advice from the district health board infection control specialists when required. A documented and signed role description for the ICN is in place. The ICN reports to the clinical services manager and FM.</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 at handovers on each shift, progress notes and clinical records. Short term care plans are developed to guide care for all residents with an infection. There are processes in place to isolate infectious residents when required. All residents are monitored daily for Covid - 19 symptoms.</p> <p>Hand sanitisers and gels are available for staff, residents, and visitors to use.</p> <p>Vaccine passports of all visitors to the facility are scanned. If visitors do not have a vaccine passport, they are denied entry to the facility. Exceptions would be considered following discussion with the FM and advice from UCG head of resident risk for visitors to residents who are receiving palliative care.</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</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at UC Churtonleigh. The ICN who is responsible for implementing the infection control liaises with the infection control committee who meet three monthly and as required.</p>

<p>of the organisation.</p>		<p>Infection control reports are discussed at the facility's 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>External resources and support are available through external specialists, microbiologist, GP, wound nurse and district health board when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by the facility management team.</p> <p>Infection prevention and control resources were organised and available should a resident infection or outbreak occur.</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>UC Churtonleigh has documented policies and procedures in place that reflect current best practice relating to infection prevention and control.</p> <p>Staff were observed to be complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The ICN is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand hygiene and standard precautions. Annual infection control training is included in the mandatory in-services that are held for all staff. Staff have completed infection control education in the last 12 months. The ICN has access to an online training system with resources, guidelines, and best practice. The ICN has completed infection control audits.</p> <p>Ministry of Health and Covid -19 information is available to all visitors to the facility.</p> <p>Education for residents occurs informally on a one-to-one basis and includes advice about hand hygiene, Covid -19, and the requirement to stay in their rooms if they have an infection.</p>
<p>Standard 3.5: Surveillance</p>	<p>FA</p>	<p>Surveillance is an integral part of the infection control programme. The purpose and methodology are described in the UCG 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>policy in use at the facility. The ICN uses the information obtained through surveillance to determine infection control activities, resources and education needs within the service.</p> <p>Monthly infection data is collected for all infections based on standard definitions. Infection control data is monitored and evaluated monthly and annually. Trends are identified and analysed, and corrective actions are established where trends are identified. These, along with outcomes and actions are discussed at the infection control meetings, quality, and staff meetings. Meeting minutes are available to staff.</p> <p>There has been one outbreak of a respiratory infection since the last audit. Interview with the ICN and GP and review of documentation confirmed the outbreak had been well managed.</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 clinical services manager, they provide support and oversight for enabler and restraint management in the facility. The restraint coordinator is conversant with restraint policies and procedures.</p> <p>On the day of the audit, one resident was using a restraint (lap belt). No residents were using enablers. A similar process is followed for the use of enablers as is used for restraint use.</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. Review of restraint and enabler use is completed and discussed at all quality, staff, and clinical meetings</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy.</p> <p>An assessment and management process is followed for the use of both restraints and enablers which ensures the ongoing safety and wellbeing of residents. The restraint co-ordinator explained the process for determining approval, for recording, monitoring, and evaluating any restraints or enablers used. The GP at interview confirmed involvement with the restraint approval process.</p>

		<p>Family/whānau approval is gained should any resident be unable to do so and any impact on family is also considered. This was evidenced by documentation and files viewed.</p> <p>Training for all staff occurs at orientation and annually.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The restraint/enabler policy details the process for assessment. Assessment covers the need, alternatives attempted, risk, cultural needs, impact on the family, any relevant life events, any advance directives, expected outcomes and when the restraint will end. A completed assessment template was sighted for the resident using restraint evidencing assessment, including consultation with family and GP.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Restraint and enablers are only used to maintain resident safety and only as a last resort. The restraint coordinator discusses alternatives with the resident, family/whānau, GP, and staff. Alternatives include low beds, perimeter mattresses, and sensor mats. Documentation includes the method approved, when it should be applied, frequency of monitoring and when it should end. It also details the date, time of application and removal, risk/safety checks, food/fluid intake, pressure area care, toileting, and social interaction during the process.</p> <p>Review of documentation and interviews with staff confirmed that restraint monitoring is carried out in line with UCG policy.</p> <p>A restraint register is maintained and reviewed by the restraint coordinator who shares the information with staff at the quality, staff, and clinical meetings.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>All restraints are reviewed and evaluated as per UCG policy and requirements of the standard. Use of restraints and enablers is evaluated three monthly or more often according to identified risk. The evaluation includes a review of the process and documentation, including the resident's care plan and risk assessments, future options to eliminate use and the impact and outcomes achieved. Evaluations are discussed at the quality, staff, and clinical meetings.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p>	FA	<p>A review of documentation and interview with the restraint coordinator demonstrated the monitoring and quality review of the use of</p>

<p>Services demonstrate the monitoring and quality review of their use of restraint.</p>		<p>restraints. The internal audit schedule was reviewed and included review of restraint minimisation. The content of the internal audits included the effectiveness of restraints, staff compliance, safety, and cultural considerations. Staff monitor restraint related adverse events while restraint is in use. Any changes to policies, guidelines or education are implemented if indicated. Data reviewed, minutes and interviews with staff including RNs and caregivers confirmed that the use of restraint is only used as a last resort.</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	There is an implemented annual schedule of internal audits. Areas of non-compliance from the internal audits include the implementation of a corrective action plan with sign-off by the FM when it is completed. However, analysis of trends and evaluation of outcomes requires improvement. The Ultimate Care Group has made improvements to the electronic system with regard to this, but these are not yet fully implemented.	<p>(i) Outcomes for corrective actions are not documented, inclusive of evaluations prior to sign off.</p> <p>(ii) Quality, health and safety, staff meetings do not fully inform staff of evaluations and outcomes.</p>	<p>(i) Outcomes and evaluations of corrective actions should be documented.</p> <p>(ii) Quality, health and safety, staff meetings should clearly outline corrective actions and improvements</p> <p>90 days</p>
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide</p>	PA Moderate	Due to staff turnover and leave taken, the facility does not have full 24/7 RN cover for afternoon and night shifts. RNs are replaced on both afternoon and night shifts by senior caregivers who have a	(i)The facility does not have 24/7 RN cover as required under the aged related residential care agreement, mitigation of this risk with monitoring by the district	<p>(i) Ensure there is 24/7 RN cover</p> <p>(ii) Ensure that staffing levels are set to meet both clinical and</p>

safe service delivery.		current first aid certificate and medication competencies. The FM with the assistance of head office human resources staff is currently advertising and recruiting for vacant positions.	health board has been out into place (ii) Caregiving staff mix and levels meet the aged related residential care agreement, however the layout of the facility and the domestic duties carried out by afternoon and night staff are not taken into consideration within the roster tool.	domestic requirements taking into consideration both facility layout and the needs (acuity) of residents. 60 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	The medication refrigerator temperatures and medication room temperatures are monitored daily, however the medication room temperature is consistently above the required level.	The temperature of the medication room is consistently above the required maximum level of 25°C.	Ensure that the temperature of the medication room is kept below 25°C. 30 days
Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group..	PA Moderate	Hot water temperatures are assayed monthly. However, issues with high temperatures are not addressed.	(i) Records demonstrated that the hot water temperatures had been above 45 degrees celsius for all of 2021, mitigation regarding this was auctioned during the audit and is ongoing. (ii) There is an area in the outside garden which has an unstable sump cover and a path which is inundated by tree roots, both of which are unsafe for residents and visitors.	(i) Ensure that hot water temperatures in resident areas meet the required 45 degrees celsius. (ii) Ensure that the outside environment is safe for resident and visitor mobility. 30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.