

The Ultimate Care Group Limited - Ultimate Care Palliser House

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

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 0.4 of the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

You can view a full copy of the standard 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 Palliser House
Services audited:	Hospital services - Medical services; Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 2 June 2022 End date: 3 June 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:	29

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 sections contained within the Ngā Paerewa Health and Disability Services Standard:

- ō tatou motika | our rights
- hunga mahi me te hanganga | workforce and structure
- ngā huarahi ki te oranga | pathways to wellbeing
- te aro ki te tangata me te taiao haumarū | person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita | infection prevention and antimicrobial stewardship
- here taratahi | restraint and seclusion.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the subsection in each of the sections. 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 subsections applicable to this service fully attained with some subsections exceeded
	No short falls	Subsections 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 subsections applicable to this service partially attained and of low risk

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

General overview of the audit

Ultimate Care Palliser House is part of the Ultimate Care Group Limited. It is certified to provide services for up to 32 residents requiring rest home, hospital and dementia level care. The facility is managed by a nurse manager. There have been no significant changes to services at the facility since the last audit.

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

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

Previous areas identified as requiring improvement relating to: management of quality and risk systems, including the development and implementation of corrective actions; support links for Māori residents; neurological assessments post-falls, fall risk reduction and complying with medical instructions; notification of family/whānau occurs post an incident/accident; RN cover for the dementia unit and staff training; medication allergies documentation and PRN medications documentations; long term care plans are developed in a timely manner and have sufficient detail; progress notes are current; chemicals are securely stored, and protective clothing is provided; sufficient linen and emergency supplies are now fully attained.

Recurring partially attained findings at this audit relate to: staffing levels; medication temperature monitoring; exemption for three monthly visits; short term care plans; wound care; activities; and laundry services.

Additional areas identified as requiring improvement also related to: staff appraisals; registered nurse cover; controlled medication; and cultural assessments.

Ō tatou motika | Our rights

Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people’s rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.		Subsections applicable to this service fully attained.
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Staff receive training in Te Tiriti o Waitangi and cultural safety which is reflected in service delivery. Care is provided in a way that focuses on the individual and takes into account values, beliefs, culture, religion, sexual orientation and relationship status.

Policies are implemented to support residents’ rights, communication, complaints management and protection from abuse. The service has a culture of open disclosure. Complaints processes are implemented.

Care plans accommodate the choices of residents and/or their family/whānau.

Hunga mahi me te hanganga | Workforce and structure

Includes 5 subsections that support an outcome where people receive quality services through effective governance and a supported workforce.		Some subsections 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 governance body has an understanding of the obligation to comply with Nga Paerewa NZS8134:2021.

An experienced and suitably qualified nurse manager ensures the management of the facility and the clinical and care services in the facility. A regional manager supports the nurse manager in their role.

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, and orientation and management of staff. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review.

Ngā huarahi ki te oranga | Pathways to wellbeing

Includes 8 subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
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On entry to the service information is provided to residents and their whānau and consultation occurs regarding entry criteria and service provision. Information is provided in accessible formats.

Registered nurses assess residents on admission with input from the resident and/or family/whānau. 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 at least six-monthly.

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

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education.

The activity programme is managed by an activities co-ordinator. The programme provides residents with a variety of individual and group activities and maintains their links with the community.

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

Te aro ki te tangata me te taiao haumaruru | Person-centred and safe environment

Includes 2 subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.		Subsections applicable to this service fully attained.
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There is a current building warrant of fitness. A reactive and preventative maintenance programme is implemented. All areas are accessible, safe and provide a suitable environment for residents.

Te kaupare pokenga me te kaitiakitanga patu huakita | Infection prevention and antimicrobial stewardship

<p>Includes 5 subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance.</p>		<p>Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk</p>
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The infection prevention and antimicrobial stewardship programmes are appropriate to the size and complexity of the service and include policies and procedures to guide staff. Infection data is collated, analysed, and trended. Surveillance data is reported to staff. There are organisational Covid -19 prevention and response strategies in place.

Here taratahi | Restraint and seclusion

<p>Includes 4 subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.</p>		<p>Subsections applicable to this service fully attained.</p>
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Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the restraint coordinator. On the day of the on-site audit, there were no residents using a restraint. Restraint is only used as a last resort when all other options have been explored.

Summary of attainment

The following table summarises the number of subsections 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)
Subsection	0	17	0	1	4	0	0
Criteria	0	54	0	1	4	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)
Subsection	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Ngā Paerewa Health and Disability Services Standard

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

There may be subsections in this audit report with an attainment rating of ‘not applicable’ which relate to new requirements in Ngā Paerewa that the provider is working towards. The provider will be expected to meet these requirements at their next audit.

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

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
<p>Subsection 1.1: Pae ora healthy futures</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.</p> <p>As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.</p>	Not Applicable	<p>The organisation has a Māori health action plan that identifies that Ultimate Care Group Limited (UCG) aims to improve outcomes for Māori. Strategies include but are not limited to: setting out priority areas; supporting the role of Mātauranga Māori in the development and delivery of health services; promoting a collective action (by government communities and social sectors) in working towards pae ora, and that all residents identifying as Māori will be offered the opportunity to have iwi/hapū and/or whānau representation contacted and present.</p>
<p>Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa</p> <p>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing.</p> <p>Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve</p>	Not Applicable	<p>There is a cultural safety policy that describes the procedure for identifying and meeting cultural needs, as well as physical, spiritual, and psychological needs. It includes culturally sensitive considerations and practices. However, the policy does not identify or address the cultural needs of Pacific peoples.</p>

<p>tino rangatiratanga.</p> <p>As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.</p>		
<p>Subsection 1.3: My rights during service delivery</p> <p>The People: My rights have meaningful effect through the actions and behaviours of others.</p> <p>Te Tiriti: Service providers recognise Māori mana motuhake (self-determination).</p> <p>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.</p>	FA	<p>Policy and practice include ensuring that all residents, including Māori residents', right to self-determination is upheld and they are able to practice their own personal values and beliefs. The Māori health plan identifies how Ultimate Care Group (UCG) will respond to Māori cultural needs and beliefs in relation to illness.</p>
<p>Subsection 1.4: I am treated with respect</p> <p>The People: I can be who I am when I am treated with dignity and respect.</p> <p>Te Tiriti: Service providers commit to Māori mana motuhake.</p> <p>As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.</p>	FA	<p>Staff receive training in tikanga best practice. Cultural appropriate activities have been introduced such as celebrating Waitangi Day,</p> <p>Interviews with staff confirmed their understanding of the cultural needs of Māori, including in death and dying, as well as the importance of involving family/whānau in the delivery of care.</p>
<p>Subsection 1.5: I am protected from abuse</p> <p>The People: I feel safe and protected from abuse.</p> <p>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.</p>	FA	<p>Staff interviews confirmed awareness of their obligation to report any evidence of discrimination, abuse and neglect, harassment, racism and exploitation. Interviews with staff also confirmed understanding of the cultural needs of Māori</p> <p>Staff are required to sign and abide by the UCG code of conduct and professional boundaries agreement. All staff files reviewed evidenced that these were signed. Staff mandatory training includes professional</p>

<p>As service providers: We ensure the people using our services are safe and protected from abuse.</p>		<p>boundaries. Staff interviews confirmed their understanding of professional boundaries relevant to their respective roles. Interviews with residents and families/whānau confirmed that professional boundaries are maintained by staff.</p> <p>Resident interviews described that the service promotes an environment in which in which they and their families/whānau feel safe and comfortable to raise any questions or queries.</p>
<p>Subsection 1.6: Effective communication occurs</p> <p>The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing.</p> <p>Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori.</p> <p>As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.</p>	<p>FA</p>	<p>There is policy requiring that family/whānau are advised within 24 hours of an event occurring, and this policy is fully implemented. Incident and accidents are documented and followed up, analysed and prevention measures are evaluated, and outcomes documented. The previous finding relating to open communication is fully attained, (refer 1.1.9.1 in 2008 standards).</p>
<p>Subsection 1.7: I am informed and able to make choices</p> <p>The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why.</p> <p>Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well.</p> <p>As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability</p>	<p>FA</p>	<p>The informed consent policy and the Māori health plan acknowledge Te Tiriti and the impact of culture and identity on the determinants of the health and well-being of Māori residents and requires health professionals to recognise these factors as relevant when issues of consent to health care of Māori residents arise. This includes whānau support and involvement in the decision-making, care and treatment of the resident, provided the resident has given consent for the whānau to be involved.</p>

<p>to exercise independence, choice, and control.</p>		
<p>Subsection 1.8: I have the right to complain</p> <p>The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.</p> <p>Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support.</p> <p>As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.</p>	<p>FA</p>	<p>The organisation has a complaints policy and process to manage complaints in line with Right 10 of the Code. The complaint process is made available in the admission agreement and explained by the nurse manager (NM) on the resident's admission. The complaint forms and a complaint box are also available in resident areas in the facility.</p> <p>The NM is responsible for managing complaints. There had been three complaints since the last audit. A complaints register is in place that includes the name of the complainant; date the complaint is received; the date the complaint was responded to; and the date of the resolution as well as the date the complaint is signed off. Evidence relating to the complaint is held in the complaints folder and register. Interview with the regional manager (RM) and a review of complaints indicated that complaints are investigated promptly, and issues are resolved in a timely manner.</p> <p>Interviews with the NM, staff and residents confirmed that residents are able to raise any concerns and provide feedback on services and this includes discussing and explaining the complaints process. Resident and family/whānau interviews confirmed that they are aware of the complaints process. Residents and family/whānau stated that they had been able to raise any issues.</p> <p>There is currently an open complaint with the district health board (DHB) concerning, care, activities staffing levels and lack of communication regarding Covid lockdown. This complaint has been fully investigated by the provider and a response has been sent to the DHB. The NM has undertaken staff training with regard to resident cares and has a corrective action plan in place with monitoring to ensure cares are carried out as per residents' care plans (this is ongoing). There are findings within this report regarding activities (3.3.1) and staff levels (2.3.1). Communication during lockdown was made with residents' chosen primary contacts, for them to disseminate the information to other family/whānau.</p>

<p>Subsection 2.1: Governance</p> <p>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.</p> <p>Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies.</p> <p>As service providers: Our governance body is accountable for delivering a high-quality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.</p>	<p>FA</p>	<p>The Ultimate Care Palliser House facility is part of UCG with the executive team providing direction to the service. The UCG governance body understands the obligation to comply with Nga Paerewa NZS 8134:2021 as confirmed at interview with the executive officer. These were described as the core competencies that executive management are required to demonstrate, and include understanding of the services' obligations under Te Tiriti, health equity, and cultural safety. The facility Māori health plan describes how the organisation will ensure equity.</p> <p>Families/whānau are encouraged to participate in the planning, implementation, monitoring, and evaluation of service delivery. The UCG management team has clinical governance structure in place (for example the appointment of a clinical head of resident risk) that is appropriate to the size and complexity of the service provision. The clinical operations management group report to the board monthly on the key aspects noted above.</p> <p>The facility has had three managers from October 2021 until February 2022. The current nurse manager (NM) is a clinically experienced registered nurse (RN) manager, with 15 years-experience in aged care who has been in the role for four months and has completed at least eight hours educational training as well as the UCG management orientation programs. In the absence of a NM, a RN covers the role for short periods. For longer periods the RM would appoint a temporary NM.</p> <p>The service provides rest home, hospital and dementia level care for up to 32 residents. Services are provided with all rooms as dual purpose. At the time of the audit, there were a total of 29 residents: included in these numbers were 14 rest home residents, 8 secure dementia care residents and 7 hospital residents. At the time of audit all residents were under the district health board (DHB) aged related residential care (ARRC) agreement.</p> <p>There are no residents with an occupation rights agreement.</p>
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<p>Subsection 2.2: Quality and risk</p> <p>The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.</p>	<p>FA</p>	<p>The annually reviewed, executive team approved quality and risk management plan, outlines the quality and risk management framework to promote continuous quality improvement. There are policies and procedures, and associated systems to ensure that the facility meets accepted good practice and adheres to relevant standards, including standards relating to the Health and Disability Services (Safety) Act 2001.</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 NM when completed. 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 open corrective actions regarding admission process, care plans and wound care and medication management.</p> <p>The facility holds monthly meetings for all staff, that includes; quality, health and safety, staff, caregivers, RNs and infection control and prevention with good staff attendance. Meetings minutes evidence that a comprehensive range of subjects are discussed.</p> <p>At interview, through observation and review of resident meetings minutes it was noted that residents were able to be involved in decision making/choices.</p> <p>Completed hazard identification forms and staff interviews show that hazards are identified. The hazard register sighted is relevant to the service and has been regularly reviewed and updated.</p> <p>The facility follows the UCG national adverse event reporting policy for internal and external reporting (where required) to reduce preventable harm by supporting system learnings.</p> <p>Notifications to HealthCERT under Section 31 were noted for the appointment of the NMs, and ongoing reporting regarding the lack of RN cover for shifts throughout 2021-22,</p>
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		<p>High quality health care and equality for Māori is clearly stated within the Māori Health Plan and policy.</p> <p>The previous findings relating to:</p> <p>(i) development of corrective action planning and reporting to address areas requiring improvement has been fully attained. The facility has transferred to a new IT system and keeps fully detailed hard copy minutes of meetings where CARs are evidenced as fully documented, plans developed and followed up with outcomes noted and signed off (1.2.3.6 in the 2008 standards).</p> <p>(ii) monitoring of neurological observations, prevention and following GP instructions post falls (1.2.4.3 in the 2008 standards) has been fully attained.</p>
<p>Subsection 2.3: Service management</p> <p>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.</p> <p>Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools.</p> <p>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.</p>	<p>PA Moderate</p>	<p>Ultimate Care Palliser House policy includes the rationale for staff roster and skill mix, inclusive of a NM's roster allocation tool to ensure staffing levels are maintained at a safe level. Interviews with residents, relatives and staff confirmed that staffing levels are not always sufficient to meet the needs of residents. Rosters reviewed evidenced that staff were replaced when sick by other staff members picking up extra shifts and the use of agency caregivers. Laundry/cleaning staff are rostered on seven days per week (three and a half hours/day for laundry and four hours per day for cleaning).</p> <p>The NM works 40 hours per week, Monday to Friday, and is available on call for emergency issues. In additional staff are supported by the UCG 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 all shifts The RM with the assistance of head office human resources staff is currently advertising and recruiting for vacant positions.</p> <p>The NM and an RN are interRAI trained and caregivers complete Careerforce training in New Zealand Qualification Standards (NZQA)</p>

		<p>to level four.</p> <p>There is an implemented annual training programme over a two-yearly cycle. Due to a Covid-19 outbreak this year the program is currently in catch up mode ensuring that the cycle will be fully met.</p> <p>Annual performance appraisals have not been completed for all staff requiring these and three-monthly reviews have not 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 non acute medical cares. All RNs, enrolled nurses and level four caregivers are current first aid certificate holders.</p> <p>An annual resident and relative satisfaction survey was completed in 2021, with an average rating of 80% approval. Corrective actions were raised around: domestic services with part time staff being employed; improvements to meal services with choices to be offered especially for evening meals, and a new van for activities (currently the facility is able to share a van with their sister facility in Masterton until such time as the new van is serviceable).</p> <p>Support systems promote health care and support worker wellbeing, and employee support services are available as required, as well as support for staff and whānau during covid-19 lockdowns.</p> <p>The service collects both staff and resident ethnicity to inform data regarding Māori health information.</p> <p>The previous findings relating to:</p> <p>(i) a designated appropriately experienced RN with responsibility for the dementia unit has been fully attained (1.2.8.1 in the 2008 standards).</p> <p>(ii) staff employed to work in the dementia unit have completed training or are enrolled in training has been fully attained (1.2.7.3 in</p>
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		<p>the 2008 standards).</p> <p>(iii) the staff mix and skills level (inclusive of safe staffing levels) remains partially attained at this audit (1.2.8.1 in the 2008 standards).</p>
<p>Subsection 2.4: Health care and support workers</p> <p>The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs.</p> <p>Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.</p> <p>As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.</p>	FA	<p>Human resource management practices follow policies and processes which 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; reference 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>There is a documented and implemented orientation programme and staff training records show that training is attended. There was recorded evidence of staff receiving an orientation, with a generic component specific to their roles, on induction. Staff interviews confirmed completing this and stated that it was appropriate to their role.</p> <p>Records reviewed showed that ethnicity data is collected, recorded, and used in accordance with Health Information Standards Organisation (HISO) requirements</p>
<p>Subsection 3.1: Entry and declining entry</p> <p>The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs.</p> <p>Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care.</p> <p>As service providers: When people enter our service, we adopt a</p>	FA	<p>The admission policy requires the collection of information that includes but is not limited to ethnicity; spoken language; interpreter requirements; iwi; hapū; religion; and referring agency. Ethnicity, including Māori, is collected and analysed by the service.</p> <p>The organisation has a Māori health action plan. The plan identifies that UCG aims to improve outcomes for Māori and that all residents identifying as Māori will be offered the opportunity to have iwi/hapū and/or whanau representation contacted and present. The NM described progress on plans to develop relationships with identified Māori service provider groups and organisations within the</p>

<p>person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.</p>		<p>community.</p>
<p>Subsection 3.2: My pathway to wellbeing</p> <p>The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing.</p> <p>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.</p> <p>As service providers: We work in partnership with people and whānau to support wellbeing.</p>	<p>PA Low</p>	<p>Registered nurses are responsible for all residents' assessments, care planning and evaluation of care. Resident care plans are developed using an electronic system.</p> <p>Initial care plans are developed with the residents/enduring power of attorney (EPOA) consent. They are based on data collected during the initial nursing assessments, which includes dietary needs; pressure injury; falls risk and social history and information from pre-entry assessments completed by the needs assessment coordination service or other referral agencies. However, these require improvement.</p> <p>The individualised long term care plans (LTCPs) are developed with information gathered during the initial assessments and the interRAI assessment and completed within three weeks of the residents' admission to the facility. The area requiring improvement from the previous audit is now closed. (1.3.3. in the 2008 standards).</p> <p>Interview with residents and family/whānau confirmed that they had consented to, and had had input into, the care planning process. All resident files contained a signed informed consent form.</p> <p>The residents' activities assessments are completed by the activities co-ordinator in conjunction with the RN within three weeks of the residents' admission to the facility. Information on residents' interests, family and previous occupations is gathered during the interview with the resident and/or their family/whānau and documented. The activity assessment includes a cultural assessment which is designed to gather information about cultural needs, values, and beliefs, however these require improvement.</p> <p>Long term care plans describe interventions in sufficient detail to meet</p>

	<p>residents' current assessed needs. The area identified for improvement from the previous audit is now closed (1.3.5. in the 2008 standards). Early warning signs and risks to guide safe care when there is deterioration in a resident's condition are recorded in the long-term care plans.</p> <p>Short-term care plans are developed for the management of acute problems. The area identified for improvement from the previous audit is now closed (1.3.5. in the 2008 standards).</p> <p>A general practitioner (GP) visits the facility weekly. The initial medical assessment is undertaken by GP following admission. Residents have reviews by the GP three monthly and when their health status changes. However, there is no documented evidence of the exemption from monthly GP visits when the resident's condition is considered stable. This area identified for improvement from the previous audit remains open (1.3.3 in the 2008 standards).</p> <p>Contact details for family are recorded on the electronic system, family/whānau/EPOA interviews and resident records evidenced that family are informed where there is a change in health status. Documentation and records reviewed were current. The GP interviewed stated that there was good communication with the service. The facility has access to an after-hours service. A physiotherapist visits the facility weekly and reviews residents referred by the GP, NM, or RNs.</p> <p>There was evidence of wound care products available at the facility. The review of the wound care plans evidenced that wounds were assessed in a timely manner. Where wounds required additional specialist input, this was initiated. However, wound care is not being carried out in accordance with policy or best practice. This area for improvement identified at the previous audit remains open (1.3.6. in the 2008 standards).</p> <p>Policies and protocols are in place to ensure continuity of service delivery. Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies</p>
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		<p>and products they require to meet those needs. 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. Staff receive handover at the beginning of their shift using the electronic system with additional input from the RNs.</p> <p>The nursing progress notes are recorded and maintained and include details of assistance given, GP visits, accidents and incidents and pro re nata (PRN) medications administered. The RN reviews are carried out as per UCG policy. The two areas for improvement identified at the previous audit are now closed (1.3.8 in the 2008 standards).</p> <p>Monthly observations such as weight and blood pressure were completed and are up to date.</p> <p>Long term care plans are formally evaluated every six months in conjunction with the interRAI re-assessments and if there is a change in the resident's condition. The evaluations include the degree of achievement towards meeting desired goals and outcomes. When progress is different from expected, changes to the care plan are initiated in consultation with the resident and/or family. 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>Residents interviewed confirmed assessments are completed according to their needs and in the privacy of their bedrooms.</p> <p>The Māori care plan, which is part of the electronic system, would be used for any resident who identifies as Māori. It is developed to assist Māori residents to identify their own pae ora outcomes. However, there were no residents who identify as Māori in the facility on the day of the audit.</p>
<p>Subsection 3.3: Individualised activities</p> <p>The people: I participate in what matters to me in a way that I like.</p>	<p>PA Moderate</p>	<p>The residents' activities programme is developed and implemented by an activities co-ordinator. They are assisted by two volunteers. However, the programme for residents living in the dementia unit is</p>

<p>Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga.</p> <p>As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.</p>		<p>not overseen by a diversional therapist as required.</p> <p>Activities planning covers a seven-day period. The activities programme is displayed in the communal areas and on the individual resident noticeboards. The activity programme describes activities for the residents Monday to Friday 10.00am to 4 pm. There is a combined plan for activities for both the rest home/hospital wing and the dementia unit. On the weekends caregivers have responsibility for implementing the programme. However, the activity programme is not implemented as per programme displayed. The area requiring improvement from the previous audit remains open (1.3.7 in the 2008 standards).</p> <p>The residents' activities assessments are completed 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 their family and documented. The residents' activity needs are reviewed six monthly at the same time the care plans are reviewed and are part of the formal six-monthly multidisciplinary review process.</p> <p>For residents living in the secure dementia unit long term care plans contain strategies for minimising episodes of challenging behaviours and a description of how the behaviour of the residents is best managed over a 24-hour period.</p> <p>There are additional nutritious snacks available for residents in the secure dementia unit over a 24-hour period.</p> <p>The activity programme has included Māori language sessions and armchair travel sessions.</p> <p>A facility van is used for outings into the community. Church services are held fortnightly.</p>
<p>Subsection 3.4: My medication</p>	<p>PA Moderate</p>	<p>A current medication management policy identifies all aspects of</p>

<p>The people: I receive my medication and blood products in a safe and timely manner.</p> <p>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.</p> <p>As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>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.</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.</p> <p>All medications are stored securely, however, the medication refrigerator temperatures and medication room temperatures are not monitored as per UCG policy. This area for improvement identified in the previous audit remains open (1.3.12 in the 2008 standards).</p> <p>Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration however, weekly checks of medications and six monthly, controlled drug (CD) stocktakes are carried out by the pharmacist but not signed for in the CD register in line with policy and legislation.</p> <p>The staff observed administering medication demonstrated knowledge and compliance with the medicine administration policies and procedures. At interview they 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 or EN oversees the use of all PRN medicines and documentation made regarding effectiveness on the electronic medication record and in the progress notes was sighted. The area for improvement identified in the previous audit is now closed (1.3.12 in the 2008 standards).</p> <p>Current medication competencies were evident in staff files.</p> <p>Resident allergies and sensitivities are documented on the electronic medication chart and in the resident's electronic record. The area for</p>
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		<p>improvement identified in the previous audit is now closed (1.3.12 in the 2008 standards).</p> <p>Education for residents regarding medications occurs on a one-to-one basis by the GP, NM or RN. Medication information for residents and whānau can be accessed online as needed.</p> <p>There were no residents self-administering medication on the day of the audit. Standing orders are not used.</p> <p>The UCG medication policy describes use of over-the-counter medications and traditional Māori medications and the requirement for these to be discussed with, and prescribed by, a medical practitioner. Interview with the GP confirmed that they would discuss the use of over-the-counter medications and traditional Māori medications with residents and their whanau when required.</p> <p>The UCG medication policy and Māori health plan outlines the requirements for support, advice, and treatments options for Māori residents.</p>
<p>Subsection 3.5: Nutrition to support wellbeing</p> <p>The people: Service providers meet my nutritional needs and consider my food preferences.</p> <p>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.</p> <p>As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.</p>	<p>FA</p>	<p>A nutritional assessment is undertaken by the RN for each resident on admission 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 cook at interview confirmed awareness of the dietary needs, likes, dislikes and cultural needs of residents. For residents identifying as Māori information would be gathered regarding nutritional needs and preferences during the initial assessment and during the development of their individual Māori care plan.</p> <p>All meals are prepared on site and served in the dining rooms or in the residents' rooms if requested. The temperature of food served is taken and recorded. Residents were observed to be given sufficient time to eat their meal and assistance was provided when necessary.</p> <p>The food service is provided in line with recognised nutritional</p>

		<p>guidelines for older people. The seasonal menu has been developed by a dietitian. The food control plan expiry date is 27th June 2022.</p> <p>The kitchen was observed to be clean, and the cleaning schedules sighted.</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> <p>Discussion and feedback on the menu and food provided is sought at the residents' meetings and in the annual residents' survey.</p>
<p>Subsection 3.6: Transition, transfer, and discharge</p> <p>The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service.</p> <p>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.</p> <p>As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.</p>	FA	<p>There is an UCG resident transfer/discharge policy.</p> <p>Transition, exit, discharge, or transfer is managed in a planned and coordinated manner and includes ongoing consultation with residents and family/whānau. The service facilitates access to other medical and non-medical services. Residents/whānau are advised of options to access other health and disability services and social support or Kaupapa Māori agencies if indicated or requested.</p> <p>A transfer form accompanies residents when a patient is moved to another service or facility.</p> <p>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>Interviews with the NM and RN and review of residents' files</p>

		confirmed there is open communication between services, the resident, and the family/whānau. Relevant information is documented and communicated to health providers
<p>Subsection 4.1: The facility</p> <p>The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely.</p> <p>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.</p> <p>As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.</p>	FA	<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 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. All resident areas can be accessed with mobility aides. There are accessible external courtyards and gardens. All external areas have outdoor seating and shade and can be accessed freely by residents and their visitors.</p> <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. Observation and interviews with residents confirmed that there was enough space to accommodate: personal items; furniture; equipment and staff as required.</p> <p>Areas can be easily accessed by residents, family/whānau, 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/whānau confirmed that residents can move freely around the facility and that the accommodation meets residents'</p>

		<p>needs.</p> <p>Interview with the RM advised that any planned alterations or additions for the facility would be identified in the Māori health plan and the service would link into the DHB Māori health unit for consultation.</p>
<p>Subsection 4.2: Security of people and workforce</p> <p>The people: I trust that if there is an emergency, my service provider will ensure I am safe.</p> <p>Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau.</p> <p>As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.</p>	FA	<p>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. Staff files and training records demonstrated that orientation and mandatory training includes emergency and disaster procedures and fire safety.</p> <p>There are systems and process in place to ensure the facility is secure over night with all exits being checked and locked at dusk with a call bell for visitors or returning residents to alert staff.</p> <p>The previous finding regarding sufficient supplies to ensure sustainability in an emergency situation is now closed (1.4.7.1 in 2008 standards).</p>
<p>Subsection 5.2: The infection prevention programme and implementation</p> <p>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.</p> <p>Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant.</p> <p>As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p>	FA	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection prevention (IP) and control programme is reviewed annually and is linked to the quality and business plan.</p> <p>There are documented policies and procedures in place that reflect current best practice relating to infection prevention and control.</p> <p>Infection prevention and control resources, including personal protective equipment (PPE), were available should a resident infection or outbreak occur. Staff were observed to be complying with the infection control policies and procedures. Staff demonstrated knowledge of the requirements of standard precautions and were able to locate policies and procedures. Ultimate Care Group have a</p>

		<p>pandemic response plan in place which is reviewed and tested at regular intervals. There are processes in place to isolate infectious residents when required. There has been one outbreak since the previous audit, Covid 19. This was managed with input from Public Health, UCG senior management team and the DHB.</p> <p>The infection control nurse (ICN) is the NM. They are newly appointed and have enrolled in the Ministry of Health online training. 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. Infection control audits have been completed.</p> <p>Educational resources in te reo Māori can be accessed online if needed. All residents are included and participate in IP. Staff are trained in cultural safety.</p>
<p>Subsection 5.4: Surveillance of health care-associated infection (HAI)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p> <p>As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.</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 policy. 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 quality and staff meetings. Meeting minutes are available to staff.</p> <p>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</p>

		<p>processes in place to isolate infectious residents when required.</p> <p>Ultimate Care Group collects data on all residents which includes ethnicity.</p> <p>Education for residents and their whanau regarding infections occurs on a one-to-one basis by the GP, NM or RN and includes advice and education about hand hygiene, medications prescribed and requirements if appropriate for isolation.</p> <p>Ministry of Health information and Covid-19 information is available to all visitors to the facility.</p>
<p>Subsection 5.5: Environment</p> <p>The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment.</p> <p>Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible.</p> <p>As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobial resistant organisms.</p>	PA Moderate	<p>Visual inspection of the on-site laundry demonstrated the implementation of a clean/dirty process for the washing, drying, and handling of personal clothes and linen.</p> <p>All linen and personal clothing is laundered on-site. However, the laundry service is not appropriate for the size and scope of the facility. The service uses a non-commercial washing machine. This machine has a capacity of 7-10kg and uses a cold or warm wash only. This area requires improvement. The area for improvement from the previous audit remains open (1.4.6 in the 2008 standards).</p> <p>Clean laundry is carried to a drying room (external to the building) which has a commercial dryer with adequate clean space for folding linen and resident's clothing before it is transported to the facility. A dedicated cleaning/laundry part time staff member works each morning weekday and caregivers also complete cleaning and laundry tasks over the 24-hour period.</p>
<p>Subsection 6.1: A process of restraint</p> <p>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.</p> <p>Te Tiriti: Service providers work in partnership with Māori to</p>	FA	<p>The restraint approval process is described in the UCG restraint minimisation policy. Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of restraint. Assessment covers the need, alternatives attempted, risk, cultural needs, impact on the family/whānau, any relevant life events, any advance directives, expected outcomes and when the restraint will end. The internal audit</p>

<p>ensure services are mana enhancing and use least restrictive practices.</p> <p>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.</p>		<p>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.</p> <p>The UCG restraint lead is the head of resident risk, and they described the organisation's commitment to restraint minimisation and implementation across the organisation.</p> <p>Use of restraint is reported to the UCG governing body and includes data gathered and analysed monthly that supports the ongoing safety of residents and staff. Data includes types of restraint used, reasons for using restraint and length of time restraint is used. Family/whānau approval is gained should any resident be unable to consent and any impact on family/whānau is also considered.</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 use is completed and discussed at all staff meetings.</p> <p>On the day of the audit, there were no residents using a restraint at UCG Palliser House.</p>
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Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our 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 2.3.1</p> <p>Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.</p>	<p>PA</p> <p>Moderate</p>	<p>(i) The facility cannot meet the DHB ARRC agreement requirement of 24/7 RN cover. Mitigation of this risk has been put into place with the RN duty being covered by an enrolled nurse or a level 4 caregiver.</p> <p>(ii) There is a rationale for the staff roster and skill mix inclusive of the manager’s roster tool, however this shows the staff level to be 19% below the planned level.</p> <p>(iii) Annual staff appraisals are required to be carried out at least 12 monthly for all staff, however these timeframes are not met.</p>	<p>(i) The DHB ARRC agreement requirements for 24/7 RN cover is not met, Rosters show that the covering staff member is not always over and above the normal staffing level.</p> <p>(ii) Staffing for resident acuity, facility layout and laundry/ domestic duties undertaken by caregivers does not consistently meet safe requirements.</p> <p>(iii) Annual staff appraisals have not been carried out as required.</p>	<p>(i) The service is to ensure there is 24/7 RN cover.</p> <p>(ii) Ensure that there is sufficient and safe staffing levels to meet residents’ needs.</p> <p>(iii) Ensure that staff appraisals are completed annually.</p> <p>30 days</p>

<p>Criterion 3.2.1</p> <p>Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this.</p>	<p>PA Low</p>	<p>Long term care plans are developed with in the required timeframe. However, interim care plans are not consistently developed within the required timeframe. In two out five care plans reviewed the interim care plan which guides care in the first three weeks after admission had not been developed as required.</p>	<p>Interim care plans are not developed consistently within the required timeframe following admission.</p>	<p>Ensure that interim care plans are developed within the required timeframe following admission.</p> <p>90 days</p>
<p>Criterion 3.3.1</p> <p>Meaningful activities shall be planned and facilitated to develop and enhance people's strengths, skills, resources, and interests, and shall be responsive to their identity.</p>	<p>PA Moderate</p>	<p>i) There is an activity programme which is displayed on the facility notice boards. However, the activity programme includes activities for the residents living the dementia unit is not reviewed by a diversional therapist.</p> <p>ii) The activity plan covers both rest home, hospital and dementia level residents. It specifies which activities will be held in which area. The plan describes activities to be implemented between 10am and 4pm. Activities for residents living in the dementia wing are planned for an hour and a half three mornings a week and for an hour in the afternoon three times a week but this varies week to week. Activities listed for the weekend include garden walks and movies. However, interviews with staff, residents and families and observation evidenced that activities are not implemented as per activity plan displayed.</p>	<p>i) There is no oversight of the activity programme by a diversional therapist.</p> <p>ii) Activities are not implemented and documented as per activity programme displayed.</p>	<p>i) Ensure that a diversional therapist has oversight of the activity programme for residents living in the dementia unit.</p> <p>ii) Ensure that activities are implemented and documented as per activity programme displayed.</p> <p>60 days</p>
<p>Criterion 3.4.3</p> <p>Service providers ensure competent health care and</p>	<p>PA Moderate</p>	<p>i) Medications are stored securely in a locked room. However, temperature of the medication room is not recorded. Recording</p>	<p>i) The temperature of the medication room is not recorded. The temperature</p>	<p>i) Ensure that monitoring and recording of medication room and</p>

<p>support workers manage medication including: receiving, storage, administration, monitoring, safe disposal, or returning to pharmacy.</p>		<p>of the temperature of the medication refrigerator is inconsistent.</p> <p>ii) Administration of controlled drugs is documented in line with legislation. However, the weekly check of controlled drugs does not occur consistently. The six monthly stocktake of CDs by the pharmacist which was due in December was carried out, however the CD register was not signed as required in policy and legislation.</p>	<p>of the medication refrigerator is recorded inconsistently.</p> <p>ii) The weekly check of medications is inconsistent. The required six monthly stocktake of medications did occur but the CD register was not completed by the pharmacist.</p>	<p>refrigerator temperatures is carried out in accordance with UCG policy.</p> <p>ii) Ensure that the check of medications occurs weekly. Ensure that required stocktake of medications occurs six monthly in accordance with UCG policy and legislation.</p> <p>30 days</p>
<p>Criterion 5.5.4</p> <p>Service providers shall ensure there are safe and effective laundry services appropriate to the size and scope of the health and disability service that include:</p> <p>(a) Methods, frequency, and materials used for laundry processes;</p> <p>(b) Laundry processes being monitored for effectiveness;</p> <p>(c) A clear separation between handling and storage of clean and dirty laundry;</p> <p>(d) Access to designated areas for the safe and hygienic storage of laundry equipment and chemicals. This shall be reflected in a written policy.</p>	<p>PA Moderate</p>	<p>All linen and personal clothing is laundered onsite. However, the laundry service is not appropriate for the size and scope of the facility. Shortcomings were identified despite assurances from management that processes were satisfactory. There is one large domestic washing machine being used for all laundry. The temperature of the wash cycles is not measured. The product used in the washing machine is not used according to manufacturer's instructions. For example, on the product container the instructions describe different amounts of product to be used for different levels of soiling however there is a chart on the wall which describes how much product to use for the size of the load, not the amount of soiling. Interview with the staff member working in the laundry confirmed that they followed the instructions on the wall not on the product container. The load being washed when the staff member was interviewed was a mix of incontinence</p>	<p>Laundry equipment and products do not meet the needs of infection control and prevention.</p>	<p>Ensure that laundry equipment and products meet the requirements for infection prevention and control.</p> <p>90 days</p>

		sheets (Kylies), sheets and personal items such as socks and underpants. The water was lukewarm. Laundry audits were not available. Soiled items are hosed off in a sluice sink in the laundry and soaked in buckets in an anti-stain product for eight hours prior to washing.		
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Specific results for criterion where a continuous improvement has been recorded

As well as whole subsections, individual criterion within a subsection 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 subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our 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.