The Ultimate Care Group Limited - Ultimate Care Palliser House

Introduction

This report records the results of a Partial Provisional 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 Palliser House
Services audited:	Hospital services - Medical services; Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 18 June 2019 End date: 19 June 2019

Proposed changes to current services (if any): The re-opening of the facility previously called Ultimate Care Greytown where rest home and hospital services were provided.

The new premise name is to be Ultimate Care – Palliser House. The service will provide rest home, hospital services (geriatric and medical) and the addition of dementia services. There will be 12 dual purpose beds and 20 dementia beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 0

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.

General overview of the audit

Ultimate Care Palliser House, formerly Ultimate Care Greytown, closed in 2017 and provided rest home and hospital services. When reopened, the service will provide rest home, hospital services (geriatric and medical) and dementia services. The facility was unoccupied on the days of the audit.

This partial provisional audit was undertaken to establish the level of preparedness to provide services in an existing facility with 12 dual purpose beds and 20 dementia beds. The audit was conducted against the relevant Health and Disability Service Standards and the national age residential care contract.

There were 12 areas identified as requiring improvement at this audit relating to: annual practising certificates; recruitment of appropriate staff; staff orientation; implementing the training programme; service provider availability; handling waste and

hazardous substances; availability of equipment; toilets/showers/bathing facilities; use of a dual-purpose room; cleaning and laundry services; emergency systems; and heating.

Consumer rights

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Organisational management

The Ultimate Care Group Limited is the governing body responsible for the services to be provided at Ultimate Care Palliser House. The scope, direction, mission and goals of the organisation are documented and displayed.

Ultimate Care Palliser House is managed by an appropriately qualified and experienced facility/nurse manager who is responsible for facility management and the oversight of clinical service provision. The facility/nurse manager is a registered nurse, who is supported by the regional clinical quality manager.

The Ultimate Care Group Limited's human resource policies and procedures guide practice at Ultimate Care Palliser House.

Proposed rosters reflect the staffing requirements for the new facility.

Continuum of service delivery

The service has policies and processes in place to guide planned activities. The service has a planned activity programme in place, with evidence of diversional therapist input.

Ultimate Care Palliser House medicine management system is based on the policies, procedures and system used throughout Ultimate Care Group nationally. The treatment and medicines room is fit for purpose. The electronic medicines management system used in other Ultimate Care Group facilities will be implemented at Ultimate Care Palliser House.

The food service policies and procedures are current and had been reviewed by a registered dietitian to ensure food services meet the nutritional needs of potential residents.

Safe and appropriate environment

The facility has a current building warrant of fitness. A planned, preventative and reactive maintenance programme is available that complies with legislative requirements.

The facility has twelve dual purpose rooms of which eight have an ensuite bathrooms and four that have an ensuite toilet. The 20 dementia wing rooms share communal toilets and shower facilities. The rooms are spacious enough to allow for resident cares and ease of movement. There are accessible and safe external areas with shade for residents and their families/visitors. There is a monitored call bell system for residents to summon help when needed. Essential emergency and security systems are in place to ensure resident safety with six monthly trial evacuations planned.

Policies and processes are in place for waste management, cleaning and laundry.

Restraint minimisation and safe practice

Policies and procedures comply with the standard for restraint minimisation and safe practice.

The service has policies and procedures to guide practice should they need to use restraint. The restraint minimisation programme defines the use of restraints and enablers. The restraint coordinator is the facility/nurse manager and has a job description for this role. There is a restraint register in place.

Infection prevention and control

The infection prevention and control policies and processes guide infection prevention and control practice within the organisation.

The infection control programme content and detail is appropriate for the size, complexity and degree of risk associated with the service.

Specialist infection prevention and control advice can be accessed from the Wairarapa District Health Board; microbiologist, general practitioners and infection control specialists if needed.

The facility/nurse manager is the infection control coordinator and has a job description in place for this role. The internal audit programme includes audit forms to review infection control processes. Pandemic resources are available in readiness should an infection control event occur.

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	8	0	9	0	0	0
Criteria	0	25	0	12	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Ultimate Care Palliser House is part of The Ultimate Care Group (UCG) with the clinical quality team providing support to the facility and were present during this audit. Ultimate Care Group has a documented vision, mission and values statement and this is displayed in the main corridors of the facility. The facility has a business plan specific to Ultimate Care Palliser House that includes: the facility's objectives; strategy and method of review. The induction checklist identifies that new staff will be made aware of these at induction. The facility is managed by a facility/nurse manager (FNM) who has been in this position for three weeks. The FNM has over 12 years previous experience in management roles within age care facilities, including 18 months as the manager at another age care facility and over 30 years' experience within aged care services. The FNM is a registered nurse (RN) with a current practising certificate and will be responsible for the management and oversight of clinical care at the facility. The FNM is supported in the role by the UCG's clinical quality team and has completed induction and orientation appropriate to the role. This is an existing unoccupied facility that is proposed to utilise 32 of the 33 bed

		rooms in the facility. The remaining bedroom has been repurposed to be used as a resident dining room in the dual-purpose wing. The facility is seeking certification to provide rest home and hospital services (geriatric and medical) for up to 12 residents and dementia services for up to 20 residents. There were no beds occupied at the time of the audit. Ultimate Care Group intends to enter into a contract with the district health board (DHB) for the provision of age related residential care: rest home and hospital services and dementia care. The facility is spread over two ground floor wings. With one wing making up the secure dementia unit of 20 available beds and the other a dual-purpose wing of 12 beds. The reopening is scheduled to occur in mid July 2019 following HealthCERT approval. Ultimate Care Palliser House has developed plans to incrementally accept residents into the facility. A staffing is in place to accommodate this.
Standard 1.2.2: Service Management 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.	FA	During a temporary absence of the FNM, a facility manager from another UCG facility in the locality will be responsible for the facility, supported by the regional clinical and quality team. The regional clinical quality manager will ensure continuity of clinical services.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	The facility's rationale for recruitment and staffing selection process informs recruitment processes to ensure that sufficient suitable staff will be appointed and available to meet the needs of all residents. The UCG's national human resource management policies and procedures are implemented and meet the requirements of legislation. Employment processes for new staff has commenced, however, not all positions had been filled at the time of audit. There are systems in place to ensure that professional qualifications are validated, annual practising certificates and practitioners' certificates are current and that practitioners adhere to all professional scope of practice requirements. However, current annual practising certificates could not be verified for all staff. An orientation/induction programme is available that covers the essential components of the services provided, however, completed orientation programmes

		for all staff could not be verified as recruitment processes are not completed. A role specific performance appraisal schedule is available. The performance appraisal policy requires all staff to undergo a review three months after commencing employment and thereafter an annual performance appraisal. The two current staff had been employed for less than one month. The organisation has a documented role specific, mandatory annual education and training module. However, the programme is yet to be implemented. The FNM completed interRAI assessments training in a previous role. However, current updates of the FNM's interRAI training could not be verified.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Low	The facility currently has two staff consisting of: the FNM and the maintenance person. Recruitment processes have commenced for clinical and household staff (refer to 1.2.7.4 and 1.2.7.3). Household staff will include: laundry assistants; cleaners; and cooks; who will provide services seven days a week. The organisation's allocation of staff/duty rosters identifies that a base roster will be set according to the needs of the resident group, individuals and numbers and to ensure safe staffing, that meets the minimum requirements of the national aged related residential care contract. Rosters will be formulated two weeks in advance and from time to time the base roster will be reviewed and altered to best meet the needs of residents and facility. There is a dedicated nurses' station centrally between the two wings. Interviews and a review of proposed rosters confirmed that planned staffing will be sufficient to cover the proposed configuration of the two wings of the facility. However, implementation of the roster could not be verified at the time of the audit as not all staff were employed to validate an appropriate skill mix would be available for the acuity of the residents yet to be admitted into the facility.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The UCG policies and processes guide medication management and are in line with required legislation and guidelines. The electronic medication system is in place to meet the needs of proposed residents. The FNM has a current medication competency. The service is currently advertising and completing interviews to ensure safe staffing (refer to 1.2.7.2, 1.2.7.3, 1.2.7.4

		and 1.2.7.5). Medication areas, including storage areas, evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light. fridge where medications are kept has been calibrated, however, temperatures checks need to be completed (refer to 1.4.2.1). There was evidence of an agreement with a local Wairarapa pharmacy to provide the service with pharmaceutical services, including stocktakes. Processes are in place for self-administration of medicines including assessment of resident competencies, safe and appropriate storage of medicines and checks by nursing staff. The FNM confirmed that the service does not use standing medicines orders.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The policy on food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. Employment processes for staff involved in food provision has commenced (refer to 1.2.7.3). Orientation and training for kitchen staff is planned to be provided (refer to 1.2.7.4 and 1.2.7.5). There is a four weekly seasonal menu reviewed by an independent dietitian at organisational level in April 2019. The organisation has a templated food control plan provided by the New Zealand Aged Care Association; which is registered with the Ministry of Primary Industries. The kitchen is spacious and appropriate for service delivery, however, it was not fully operational (refer to 1.4.2.1). The nutritional assessment forms reviewed will be used for the assessment of new residents on admission to the facility. These forms are currently used in other UCG facilities and encourage residents to express their likes and dislikes. There is a documented system for informing the cook about all residents' dietary needs. Cleaning schedules are in place. Chemicals used in the kitchen are not stored securely (refer to 1.4.6.3). The service has appropriate internal audit process in place to review food services, including a process for assessing resident satisfaction.

Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	Ultimate Care Palliser House has an activities programme, reviewed by a diversional therapist from a Wellington site of the Ultimate Care Group. The activities programme includes activities from 0930 to 1500, 7 days a week. The activities programme includes aged appropriate activities relating to the needs of older people and the setting of the service. Employment processes for activities staff have commenced (refer to 1.2.7.3). There is space to allow for activities in the dementia unit as well as in the rest home/hospital. Forms are in place to complete resident assessments. Equipment for activities has been ordered (refer to 1.4.2.1). Church services/spiritual care is included in the activities programme to ensure resident needs are met regardless of denomination. In the dementia unit staff will use a 24-hour assessment wheel to monitor and inform the management of challenging behaviour. The use of this document was demonstrated during the on-site audit.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	PA Low	Documented policies and procedures for the management of waste and hazardous substances are in place. Policies and procedures take into consideration staff education, auditing, cultural requirements and specify safety requirements that comply with legislation, including the requirements for clear labelling and disposal and collecting of waste. Material safety data sheets and chemical safety data sheets will be available as confirmed in FNM interview, however, sheets were not in place at the time of audit. Staff induction checklists, and training and education programmes to be provided include the disposal of waste and safe chemical handling (refer to 1.2.7.5). Personal protective clothing and equipment has been ordered, such as aprons, gloves and masks, however, was yet to be put in place within high risk areas of the facility at the time of audit. There is sluice room, however, sluice hoses were not appropriate for use.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate,	PA Low	A current building warrant of fitness is displayed in the entrance to the facility. Buildings and plant equipment comply with legislation.

accessible physical environment and facilities that are fit for their purpose.		There is an implemented planned and reactive maintenance schedule. There is an annual test and tag programme. The programme will include checking and calibrating of clinical equipment annually and before use for new purchases. However, available firefighting equipment, such as hoses and extinguishers, did not evidence a current check. Not all equipment was fit for purpose and appropriately monitored ready for occupancy. Access to the facility meets the mobility and equipment needs of residents. There are ramps and rails to facilitate access for prospective residents. Outdoor areas will be able to be accessed freely by residents and their visitors. There is a decked courtyard with shade, landscaped lawns, and areas where outdoor tables, chairs and shade umbrellas will be provided. However, not all required equipment required is in place. There is sufficient equipment, consumables and signage available or on order to meet resident needs, however, not all equipment, consumables and signage was in place at the time of audit.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	PA Low	Eight dual purpose rooms have full ensuite facilities with a shower, toilet and a basin. However, not all ensuite bathrooms had a functioning light/extractor. Four dual purpose rooms have a toilet and hand basin. The 20 resident rooms in the dementia wing have access to share toilet and shower facilities. All bathrooms/toilets have: a call bell to summon assistance in an emergency; approved handrails; space to facilitate staff assistance if required; wide doorways, and hand basins. There was evidence the equipment/consumables had been ordered for bathrooms, however, these items were not in place at the time of the audit. Toilets for visitors and staff are located close to the nurse's station/reception, have a system to indicate vacancy and provide disability access.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	PA Low	All resident rooms are single rooms. The rooms viewed were noted to have sufficient space to allow residents to mobilise safely with mobility aids and assistance if required. However, not all proposed dual purpose rooms are suitable for residents assessed as requiring hospital level of care. There is space in resident rooms for prospective residents' to be able to personalise

		their rooms, with personal furniture and possessions. There are designated areas to store equipment such as: wheel chairs and walking frames safely.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The facility's dual-purpose wing has a separate centrally located lounge/dining room where residents can have their meals with other residents. In addition, a room previously used for residents has been repurposed to be utilised as a small separate dining room. There is sufficient space in each resident room for a prospective resident to have their meals in their own room if they wish. The dementia wing has a large lounge as well as two separate dining rooms, one of which will also be used for activities. The lounge area in the dementia wing has been outfitted with seating and book cases. There is evidence to confirm that furniture for lounges and dining rooms in both areas has been purchased (refer to 1.4.2.1). There are sufficient quiet areas for residents and their visitors to access if they wish.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	PA Low	Facility/nurse manager interviews and a review of proposed rosters identified that there will be at least one laundry operator and one cleaner on duty each day, seven days a week. These roles will initially be for four hours per day each and increase as resident numbers increase. Job descriptions outline the expectations of each role. Interview confirmed that laundering of all facility linen will be undertaken on-site, however, clean and dirty areas of the laundry are not clearly delineated. Cleaning products will be dispensed from an in-line system according to a cleaning procedure. Cleaning cupboards for storing equipment and chemicals are in place, however, these are not secured. Interview confirmed that material safety data sheets and chemical safety data sheets are to be sited in the laundry and cleaning room (refer to 1.4.1.6). The orientation programme and annual training programme sighted confirmed that relevant staff will receive orientation and training in cleaning and laundry processes and the safe use of the chemicals/products provided (refer to 1.2.7.5).

		The effectiveness of cleaning and laundry processes will be monitored through the internal audit process. Observation on the days of the audit noted the resident areas to be clean and tidy.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	PA Low	Ultimate Care Palliser House has a civil defence plan/disaster plan specific to the facility. In addition, the organisation has a suite of emergency policies and procedures, however, not all policies sighted were current. The orientation and the annual training programme include emergency evacuation, security, fire safety and evacuation and civil defence procedures. The annual training programme identifies that RNs and recreational staff will receive essential first aide training two yearly (refer to 1.2.7.5). A New Zealand Fire Service approved fire evacuation plan was sighted for the facility. An evacuation plan exercise is scheduled for 29 July 2019. Facility/nurse manager interview confirmed that fire drills will be conducted at least six monthly. The facility has a monitored fire alarm and there are both smoke detector and sprinkler systems throughout the building and correct signage displayed. The facility has an emergency kit with some supplies to sustain staff and residents in an emergency situation. However, not all supplies and equipment was in place on the days of the audit. There are emergency water supplies available to sustain residents and staff for seven days. However, water supplies were outdated. There are call bells to summon assistance in all residents' rooms and toilets. Rooms with an ensuite bathroom/toilet had call bells in both the bedroom and bathroom. Call bells are checked monthly by the maintenance person. Manual testing on the day of the audit confirmed that call bells were functioning. There are documented security procures and guidelines to ensure precautions are taken to prevent danger to all. These include, for example, locking the facility at dusk, restricted access after-hours, security, summoning aide, and steps to take in the advent of threat. The orientation process for staff includes essential security, window and door check and visitor security.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light,	PA Low	All residents' rooms and communal areas in the new facility have safe ventilation and external windows and some ensuite bathrooms have sky lights that provide natural light. The environment in the areas of the facility in use on the days of audit

safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		were noted to be maintained at a satisfactory temperature. However, panel heaters in residents' rooms were noted to be too hot to touch.
Standard 3.1: Infection control management 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.	FA	An infection prevention and control programme is in place. The programme's content and detail is appropriate for the size, complexity and degree of risk associated with the service. Infection control management is guided by the infection control manual developed at organisational level. The infection control programme and manuals are current. The infection control nurse (ICN) is the FNM. The ICN completed relevant training for this role and the responsibilities are clearly outlined in a position description which is signed and dated. The ICN role is supported by the infection prevention and control committee, however, employment processes for other members of the committee have not yet been completed (refer to 1.2.7.3). The ICN reports directly to the regional clinical quality advisor regarding infection control matters. Some resources are available to support the programme and any outbreak of infection, including an outbreak kit. However, not all equipment needed is in place for example; the soap, anti-bacterial gels, paper towels and appropriate signage (refer to 1.4.2.1 and 1.4.3.1). All flooring, equipment, furniture sighted is made from materials suitable for cleaning to maintain infection control principles.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint minimisation and safe practice policies and procedures comply with this standard and relevant legislation. The service has a no restraint approach and restraint is to be used as a last resort. Policies, processes and forms are available for the management of challenging behaviour. The FNM is the restraint coordinator and completed orientation and induction for this role. There is a signed job description with key performance indicators for the role of the restraint coordinator. Staff working in the dementia unit are being interviewed and will be enrolled to the dementia unit standards training where needed (refer to 1.2.7.3 and 1.2.7.5) Documentation relating to enabler use confirmed that when residents request enabler use, it is a voluntary process, requested by the residents and the least

		restrictive option to promote the residents' independence and safety.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.	PA Low	File reviewed of the FNM evidenced validation of annual practising certificate. The employment of new staff who require annual practising certificates has not been fully completed and not all the annual practising certificates required were able to be evidenced.	Not all required annual practising certificates of staff that will be employed were able to be sighted.	Ensure professional qualifications are validated for staff who require these to practise. Prior to occupancy days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	The skills and knowledge required for each position are documented in job descriptions. Interviews and the staff files reviewed for the two current staff members demonstrated that recruitment processes for staff include: reference checks; police vetting; identification verification; position specific job description; and a signed employment agreement. There is an action plan in place to recruit staff. Recruitment processes are in	The appointment of appropriate staff employed to provide safe services was unable to be verified, as not all staff were employed at the time of audit.	To recruit and commence employment of the appropriate skill mix of staff to meet future resident needs. Prior to occupancy days

		progress for a senior RN, care givers (CGs); a diversional therapist; and household staff. Interviews have been completed for an enrolled nurse (EN), CG and a cook. Employment processes for the additional staff required to meet the needs of future residents was yet to be completed at the time of audit.		
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	There are documented processes for orientation of new staff. The orientation programme sighted recorded the required areas of the services at this new facility. It requires new staff to demonstrate competency on, and/or understanding of, a number of specific functions and tasks, including: health and safety; infection prevention and control; hand hygiene; personal cares and hoist use. Review of staff files of the two staff members currently employed by the facility evidenced orientation processes were implemented. However, implementation of the orientation could not be verified for all staff as recruitment processes were not complete at the time of audit.	The orientation programme could not be verified as completed as not all staff have been appointed.	Ensure all new staff complete the required orientation/induction programme. Prior to occupancy days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	The education and training programme provides an opportunity for maintaining competencies and includes the required training topics. There are systems and processes in place to ensure that all future staff will complete their required mandatory training modules, including dementia unit standards where required, and	i) The annual training programme was not yet implemented. ii) InterRAI competency for the FNM could not be verified.	i) Implement the annual training programme. ii) Ensure RNs complete current interRAI competency assessments.

		competencies. Competency is planned to be reassessed at the time of the annual performance appraisal. Manager interview and training programme review confirmed that staff, including RNs will be provided with the opportunity to complete at least eight hours of relevant education and training hours per annum. However, implementation of the annual training programme was not able to bet evidenced. The FNM has completed induction and orientation, and some competencies, including medication management. Interview confirmed that the FNM is interRAI trained and would undergo interRAI revalidation once residents had been admitted to the facility.		Prior to occupancy days
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Low	The proposed rosters sighted for the facility demonstrated that five-stepped roster scenarios had been drafted to incrementally increase facility staffing as resident numbers increase. In all scenarios the FNM is rostered on day shift from Monday to Friday inclusive. The facility will have at a minimum: a RN and a CG on each shift; a cook, cleaner and laundry assistant on each day; and activities staff one day per week. Additional hours are planned to be allocated to each role as resident numbers increase. Activities input and oversight will also be provided by a diversional therapist from another facility in the locality to ensure activities are provided seven days a week. An initial roster (step one) for up to five residents includes: for in the dual-purpose wing one RN on every shift 7 days a week,	Proposed roster skill set mix suitability could not be validated as not all staff had been employed at the time of the audit.	Ensure staff employed are rostered to meet skill mix requirements suitable to safely meet the needs of the residents. Prior to occupancy days

		24 hours a day; and for the secure dementia unit one EN or one CG on every shift. The final roster (step five) for between 20 and 32 residents includes: for in the dual-purpose wing one RN and one CG on every shift 7 days a week, 24 hours a day; and for the secure dementia unit two staff either EN or CGs on every shift. The FNM or a senior RN (yet to be employed) will be available on call after hours for advice on clinical matters. As staff were not all employed at the time of the audit, verification of the appropriate skill set on the roster could not be evidenced.		
Criterion 1.4.1.6 Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.	PA Low	Interviews confirmed that material safety data sheets and chemical safety data sheets will made available in relevant places in the facility. However, observation evidenced material safety data sheets and chemical safety data sheets were not yet in place. Stock orders sighted and FNM interview confirmed that personal protective clothing and equipment has been ordered. However, personal protective clothing and equipment was not in place at the time of audit. There is sluice room for the appropriate disposal of body waste, however, sluice hoses did not have directional/flow nozzles.	i) Material safety data sheets, chemical safety data sheets and personal protection equipment are not available within high risk areas of the facility. ii) Sluice room water hoses do not have directional/flow nozzles.	i) Ensure material safety data sheets, chemical safety data sheets and personal protection equipment are available to staff. ii) Ensure that sluice room water hoses are fitted with directional/flow nozzles. Prior to occupancy days
Criterion 1.4.2.1 All buildings, plant, and equipment	PA Low	The facility has a current building warrant of fitness and there are processes to ensure that maintenance and serviceability checks	i) Firefighting equipment does not evidence a current	i) Ensure all equipment demonstrates evidence of a current check.

comply with legislation.		are undertaken. However, firefighting equipment did not evidence a current annual check. Evidence of appropriate use of equipment could not be verified for example; temperature checks for fridges, freezers and food as well as cleaning and service delivery. Observation identified the chiller was faulty and needed replacement; the oven needed fixing; the steriliser needed cleaning and servicing and the service bay from the kitchen into the dementia care dining room was still awaiting a roller door to ensure the safety of residents. There is a process to monitor hot water temperatures monthly. Interviews confirmed that temperatures would be assayed prior to residents being admitted to the facility. Facility/nurse manager interview, available equipment sighted and review of invoices for purchases confirmed there will be sufficient equipment and consumables available to support residents including, for example: beds; dining room tables and chairs; lounge chairs; wheel chairs; shower chairs; activities equipment; hoists; dressing trollies, anti-bacterial gels; stethoscopes and sphygmomanometers. However, not all equipment or consumables were in place at the time of audit. Directional signage had been ordered, for example, entry and exit signs. However, signage was not in place.	check. ii) Evidence that all equipment was fit for purpose could not be verified. iii) Not all ordered equipment, signage and consumables was in place.	ii) Provide evidence that all equipment is fit for purpose. iii) Ensure all required equipment, signage and consumables are in place and checked prior to occupancy. Prior to occupancy days

Criterion 1.4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.	PA Low	Bathrooms/toilets have equipment to facilitate ease of mobility and independence such as handrails. However, not all toilets/bathrooms had shower curtains, toilet paper, flowing soap and handtowels in place at the time of audit. Toilets and showers have lighting and extractor fans, however, not all ensuites had a functioning light/extractor fan.	i) Bathrooms did not have the required shower curtains, toilet paper, towels and soap. ii) Not all ensuites had a functioning light/extractor fan.	i) Ensure all bathrooms have shower curtains, toilet paper, towels and soap. ii) Ensure all ensuites have a functioning light/extractor fan. Prior to occupancy days
Criterion 1.4.4.1 Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.	PA Low	Eleven of the twelve proposed dual-purpose rooms have sufficient room to be occupied by a resident assessed as requiring hospital level care, who may require assistance to mobilise such as hoists and wheels chairs, as well as additional staff. However, one room in the rest home/hospital wing was not suitable for hospital level care. Room seven opposite the receptions/nurses' station was noticeably smaller and did not afford ease of access for additional equipment such as a hoist.	Room seven, a proposed dual-purpose room, is unsuitable for a resident assessed as requiring hospital level of care.	Ensure that room seven is not used for a resident assessed as requiring hospital level of care. Prior to occupancy days
Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.	PA Low	There is a designated laundry in the dementia wing, that includes a washing machine. However, clean and dirty areas are not clearly delineated. There is an outside room, near the laundry with a dryer for clothes drying, sorting, ironing and linen storage. There are designated cleaning cupboards for the safe and hygienic storage of cleaning equipment and chemicals in the kitchen and	i) Cleaning equipment and chemicals are not stored securely. ii) There is no clear delineation of clean and dirty areas in the laundry.	i) Ensure cleaning equipment and chemical storage is secure. ii) Ensure clear delineation of clean and dirty areas in the laundry. Prior to occupancy days

		laundry, however, these are not secured.		
Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.	PA Low	The organisation has a suite of emergency policies and procedures that are under review. However, not all policies sighted demonstrated evidence of current review. There is an emergency kit with some emergency supplies such as torches and spare batteries. However, not all supplies and equipment required to sustain staff and residents in an emergency situation were in place on the days of the audit. Essential items such as a barbeque for use in the event of the main supplies failing, additional food and continence supplies had been ordered for delivery prior to occupation. There are sufficient emergency water supplies available to sustain residents and staff for seven days. However, water supplies were last renewed in June 2016 and require replacing to ensure that they are safe for human consumption. The facility had commenced renewing water supplies on the days of the audit.	i) Emergency policies and procedures required review. ii) Not all required emergency supplies are available. iii) Emergency water supplies are outdated.	i) Ensure emergency policies and procedures demonstrate evidence of current review. ii) Ensure all required emergency supplies are available. ii) Ensure emergency water supplies a fit for human consumption. Prior to occupancy days
Criterion 1.4.8.1 Areas used by consumers and service providers are ventilated and heated appropriately.	PA Low	The facility will be heated with a combination of heat pumps in communal areas and panel heaters in residents' rooms. However, the panel heaters were noted to be too hot to touch at the time of audit.	Wall heating panels were noted to be too hot to touch.	Ensure heating will not pose a risk to residents. Prior to occupancy days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.