

# The Ultimate Care Group Limited - Ultimate Care Palliser House

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## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	The Ultimate Care Group Limited	
<b>Premises audited:</b>	Ultimate Care Palliser House	
<b>Services audited:</b>	Hospital services - Medical services; Rest home care (excluding dementia care); Dementia care	
<b>Dates of audit:</b>	Start date: 3 December 2019	End date: 4 December 2019
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	14	

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

## General overview of the audit

Ultimate Care Palliser House can provide care for up to 32 residents requiring rest home, hospital and dementia level care. There were 14 residents at that facility on the first day of the audit.

This surveillance audit was conducted against the relevant Health and Disability Service Standards and the service contract with the Wairarapa District Health Board.

The audit process included review of policies and procedures, review of resident and staff files, observations and interviews with family, residents, management, staff, a clinical nurse specialist (health of older people) and a general practitioner.

Areas requiring improvement at the partial provisional audit relating to: annual practising certificates; recruitment of appropriate staff; staff orientation; service provider availability; handling waste and hazardous substances; toilets/showers/bathing facilities not being fully functional; unsuitability of a room for dual-purpose use; emergency systems; and heating have been closed out.

Areas requiring improvement relating to the implementing the training programme; availability of equipment and cleaning and laundry services, have not been fully implemented and remain open.

Additional areas requiring improvement identified at this surveillance audit include: communication; document control; adverse events; care planning; diversional therapist oversight of the activities programme; medication management and infection control data.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

Some standards applicable to this service partially attained and of low risk.

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service is provided to residents and family as part of the resident's admission and available within the facility.

Residents, family and the general practitioner's interviews confirmed that staff are respectful of residents' needs. There is access to interpreting services if required.

There is a documented complaints management system, that includes processes to ensure that complaints are investigated, documented, corrective actions implemented where required. A complaints register is maintained. There have been no complaints to external agencies since the previous audit.

## Organisational management

<p>Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The Ultimate Care Group Limited is the governing body responsible for the services provided at Ultimate Care Palliser House. The mission and values of the organisation are documented and communicated to all concerned.

The facility is managed by an appropriately qualified and experienced facility manager who is a registered nurse. The facility manager is supported in the oversight of clinical service provision by a team of experienced registered nurses and the regional manager.

The facility has implemented the Ultimate Care Group's quality and risk management system that supports the provision of clinical care and quality improvement. Policies and procedures are reviewed by the national support office.

Quality and risk performance is regularly reported and monitored through the organisation's online reporting system. An internal audit programme is documented and implemented. Corrective action plans are documented from quality activities, with evidence of resolution of issues when these are identified.

Actual and potential risks, including health and safety risks, are identified and mitigated. There is a database to record risk, in which risks and controls are clearly documented.

The Ultimate Care Group human resource policies and procedures are implemented. Newly recruited staff undertake orientation appropriate to their role. Practising certificates for staff and contractors who require them are validated annually. An annual training programme is implemented for all staff members.

A review of rosters and service delivery staff, and resident/family interviews confirmed that there is adequate staff available.

## Continuum of service delivery

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

An InterRAI assessment is used to identify residents' needs and is completed within three weeks of admission. Medical assessments are completed by the general practitioner.

Residents' files reviewed demonstrate that needs, goals and outcomes are identified and evaluated. Documentation and interviews confirm residents and their families are informed and involved in the care planning and evaluation of care.

Handovers between shifts guide continuity of care and team work is encouraged.

Medicines management is implemented using an electronic system. Medications are administered by registered nurses, enrolled nurses and senior care givers.

The food service meets the nutritional needs of the residents. Kitchen staff have food safety qualifications. The kitchen meets food safety standards. The food control plan is current and displayed. Residents and families confirmed satisfaction with meals provided.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Some standards applicable to this service partially attained and of low risk.

There is a current building warrant of fitness. A planned, preventative and reactive maintenance programme is in place.

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

There are documented and implemented policies and procedures for cleaning and waste management. Cleaning and laundry services are monitored.

Essential emergency systems are in place. There is an approved fire evacuation plan and six-monthly trial evacuations are undertaken.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Standards applicable to this service fully attained.

The organisation implements policies and procedures that support the minimisation of restraint. There were no enablers or restraints in use at the time of audit. Staff interviews confirmed understanding of the restraint and enabler processes. Restraint education is provided to staff at orientation and as part of the annual training programme. A restraint register is maintained.

## Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Infection prevention and control surveillance is undertaken, analysed and trended. Results are reported to staff. Surveillance records showed evidence of follow-up of infection when required. Staff interviewed demonstrated current knowledge and practice of infection control principles.



## 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)
<b>Standards</b>	0	12	0	8	2	0	0
<b>Criteria</b>	0	35	0	7	3	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisation has a complaints policy and process to ensure that complaints are managed in line with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). A copy of the complaints process and a complaints form is included in the information pack provided to residents and their families on admission. Complaints forms are also available in the facility.</p> <p>The FM is responsible for complaints management. Residents and family interviews confirmed that they are aware of the process to make a complaint and their right to advocacy services, particularly in relation to the complaints process. Residents confirmed that they have not had any complaints. They stated that the FM was approachable and that they were able to raise and discuss concerns or issues with the FM and these were responded to in a timely manner.</p> <p>There is a complaint register available to document any complaints. Interview with the facility manager advised that there had been no complaints received since the re-opening of the facility. There was one complaint to the Health and Disability Commissioner in 2017, regarding resident care at the then Greytown Lifecare facility, prior to closure and prior to the re-opening of this facility as Ultimate Care Palliser House. Interview with the general manager clinical services, the regional manager and FM confirmed that UCG have implemented the recommendations of the Commissioner and the complaint is closed out. These have included: sharing the case study for education across UCG facilities; providing minutes of a clinical service manager's teleconference evidencing discussion on wound management, falls and weight loss to the commissioner; and providing a written apology to the family. Systems have been implemented to ensure adequate retention and archiving of health</p>

		<p>records in response to the complaint.</p> <p>There had been no complaints to external agencies since the re-opening of the facility as Ultimate Care Palliser House.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Low	<p>The organisation has an open disclosure policy that promotes a transparent, consistent approach to full and open disclosure where there is an instance of actual or potential adverse event and/or harm during the course of a resident's care. Completed incident/accident forms, residents' records and resident and family interviews demonstrate that family are informed if the resident has an incident/accident; a change in health status or a change in needs. Family contact is recorded on incident/accident forms and in residents' files.</p> <p>Family are included where appropriate in resident care planning meetings. This was confirmed in staff, resident and family interviews confirmed.</p> <p>The facility menu is provided to residents in the admission pack and facility activities are posted on the notice board. Family and residents interviewed stated that they are able to provide feedback and discuss issues directly with the facility manager (FM) and that any concerns or queries are addressed promptly. However, formal resident meetings are yet to be held.</p> <p>There is policy to ensure that information is supplied in a way that is appropriate for the resident and/or their family and takes account of specific language requirements and any disabilities. Interview with the FM confirmed access to external interpreter services if required. The FM stated that there were no residents at the facility requiring interpreting services at the time of the audit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The business planning template outlines the: scope; direction; mission and goals of the facility, which reflect a person/family centred approach to care for all residents. The values and mission are communicated to all concerned through the facility's information pack provided to residents and their families on admission. Staff receive this information at orientation and in key documentation such as position descriptions.</p> <p>Ultimate Care Palliser House is part of the Ultimate Care Group Limited. Communication between the FM and UCG executive management occurs at least monthly. In the month prior to the audit, UCG had implemented an organisational restructure and the Ultimate Care Palliser FM now reports to a regional manager, who is responsible for both regional quality and operational matters. The FM reported that regular contact with the regional manager occurs. The facility completes ongoing electronic reporting of events and occupancy that provides the UCG executive management team with data on progress against identified indicators (refer to 1.2.4.3 and 3.5.7). The national support office provides monthly summarised data, which is reported in graph format. The facility responds to this information with feedback on trends and activity. A sample of monthly reports showed information that monitors the service's performance is reported and includes: weight loss; infections; pressure</p>

		<p>injuries; medication errors; falls and behaviour (refer to 1.2.4.3 and 3.5.7).</p> <p>The service is managed by a FM who has been in the role for just under six months. The FM has over 28 years' experience in aged related residential care (ARRC), including previous residential facility management. Responsibilities and accountabilities of the FM are defined in a job description and individual employment agreement. The FM is responsible for clinical care and is supported by a team of five registered nurses (RN). The FM and RNs hold current annual practising certificates and have completed an induction and orientation appropriate to their roles. The team are supported by a regional manager, who is responsible for operational and quality management oversight.</p> <p>The facility is certified to provide rest home, hospital and dementia care services for up to 32 residents, with 14 beds occupied at the time of the audit. The facility has 20 dementia beds; 11 dual purpose beds; and 1 rest home only bed. Occupancy on the first day of the audit included: six residents requiring rest home level care, five residents requiring hospital level care and three residents requiring dementia level care. These numbers include one resident under the chronic health conditions contract, assessed as requiring rest home level care, who is under 65 years of age.</p> <p>The facility holds contracts with the district health board (DHB) for ARRC, chronic health conditions; respite care and residential non-aged care.</p> <p>The facility has no residents with occupational right agreements.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The UCG quality and risk management framework is documented, implemented and reviewed annually. The framework is accessed by staff to guide service delivery and manage risk.</p> <p>Policies and procedures align with the Health and Disability Sector Standards and reflect accepted good practice guidelines (1.2.4.3). The UCG management group reviews all policies in line with the document review process. Document control is managed centrally by the organisation and staff have electronic access via the UCG internal information technology (IT) network. A current electronic version is kept at the national support office and updated according to the review process. The facility maintains a hard copy set of the policy and procedure manuals on site. There are systems and process to present new and revised policies to staff.</p> <p>Each resident's information is held in a uniquely identifiable file with relevant information grouped together, that includes information such as weight records and is stored securely in a locked filing cabinet when not in use. There is an implemented system to archive files, when required that is securely locked on the premises. Archived information is easily retrievable. However, not all aspects of document control for human resource files were fully implemented.</p> <p>Quality improvement, risk management and clinical indicators are discussed at the facility's monthly combined staff, quality, health and safety and infection control meetings. Quality data and corrective actions are discussed at</p>

		<p>staff meetings. This was confirmed in staff interviews.</p> <p>Residents and family interviews stated that they are notified of facility changes and events through one-on-one conversations with the FM (refer to 1.1.9.1). Interviews with residents, including the resident under 65 years, and family confirmed that residents are satisfied that the service meets their individual needs and that they are provided with choices.</p> <p>Satisfaction surveys for residents and family are completed as part of the annual internal audit programme. A resident survey has been completed and collated at a national level for UCG. The results of the recently collated overarching UCG survey reviewed evidenced satisfaction with the services provided. The facility specific data from the resident survey at Ultimate Care Palliser House was not yet available at the time of the on-site audit. Resident and family interviews confirmed satisfaction with services.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<p>The FM is aware of situations which are required to be reported to statutory authorities, including: unexpected deaths; police involvement; sentinel events; infectious disease outbreaks and changes in key management roles. These are reported to the appropriate authority via the UCG national support office.</p> <p>Staff interviewed demonstrated understanding of the adverse event reporting process and their obligation to report all untoward events. A review of records confirmed that staff document adverse, unplanned or untoward events on incident/accident forms which are reviewed and signed off by the FM. However, there was evidence that not all adverse events are documented in the electronic system.</p> <p>Staff training records reviewed confirmed that staff receive education at orientation and as part of the ongoing training programme on incident/accident reporting processes.</p> <p>Incident/accident reports reviewed at audit confirmed that, where appropriate, the resident's family had been notified, an assessment had been conducted and observations completed. However, neurological observations were not completed in line with best practice in files reviewed. Where required corrective actions arising from incidents/accidents were implemented. Family and resident interviews confirmed that family are notified where the resident has had an incident/accident or a change in health status.</p> <p>Incident/accidents are reported, graphed, analysed and reported and discussed with staff at the combined monthly meeting.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	PA Moderate	<p>Human resource management policies and procedures are implemented and meet the requirements of legislation (1.2.3.4). The skills and knowledge required for each position are documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; police vetting; identification verification; a position specific job description; and a signed employment agreement (1.2.3.4). The</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>previous requirement for improvement to recruit suitably qualified staff has been closed out.</p> <p>Professional qualifications are validated and there are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff and contractors that required them. The previous requirement for improvement to ensure professional qualifications are validated has been closed out.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided, the organisation's policies and procedures, and dementia specific orientation for staff working in the dementia unit. Caregivers (CG) are buddied with an experienced staff member until they demonstrate competency and confidence on specific tasks, for example: hand hygiene; and moving and handling. The previous requirement for improvement to ensure all new staff complete an orientation programme has been closed out.</p> <p>Registered nurses and enrolled nurses (EN) have completed syringe driver competencies. Registered nurses and four CGs/ENs have completed medication competencies. Care staff complete annual competencies and comprehension, for example: moving and handling; hoist use; and hand washing.</p> <p>The previous requirement for improvement related to interRAI competencies and implementing the training programme has been closed out. Three of five RNs have completed interRAI assessments training and competencies. This part of the previous requirement for improvement, has been closed out.</p> <p>The organisation has a documented annual education and training module/schedule that includes topics relevant to all services and levels of care provided. The annual mandatory training programme had been implemented in the three months the facility has been open. However, this was not clearly documented in a central training record. Not all RNs have completed their required mandatory first aid training. The previous requirement for improvement relating to the implementation of the annual training</p> <p>An appraisal schedule is available; however, staff have been employed for less than one year and are not yet required to complete an annual performance appraisal.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The organisation has a documented staff duty roster allocation process in place to ensure optimal cover with appropriately skilled, educated and qualified staff. It ensures staffing levels within the facility are safe and sufficient to meet the needs of residents' acuity and the minimum requirements of the DHB contract. Staffing levels are reviewed to accommodate anticipated workloads and identified numbers and acuity of residents.</p> <p>In addition to the FM, there are five RNs, two ENs and CGs available to maintain the rosters for the provision of care (refer to 1.2.7.5). A review of duty rosters and interview with the FM identified that agency RNs are required to ensure adequate cover on all shifts. Rosters sighted reflect adequate staffing levels to meet current resident acuity and bed occupancy. The FM works in the morning from Monday to Friday inclusive. In the rest home/hospital wing there is a RN on each shift seven days per week, supported by: two CGs or ENs on morning</p>

		<p>and afternoon shifts; and one CG on the night shift. In the dementia wing there is one CG on duty each shift, seven days per week. The previous requirement for improvement to ensure staff employed are rostered to meet skill mix requirements suitable to safely meet the needs of residents has been closed (refer to 1.2.7.5).</p> <p>The FM or another RN is on call after hours, seven days a week for advice or when additional assistance is required, for both rest home/hospital and dementia wings.</p> <p>Observation of service delivery confirmed that residents' needs are being met. Interviews with residents, family and staff stated that staff are often busy, however, staffing levels meet the residents' needs. Staff confirmed that they have sufficient time to complete their scheduled tasks and resident cares.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures to guide medication management which comply with legislation, protocol and guidelines.</p> <p>An electronic medication system is used. The facility has a contract with a local pharmacy and pre-packaged medicine is checked by the RN on delivery. However, weekly checks of medicines are not conducted consistently where required and documentation of expiry/use by dates for medications is not carried out as required.</p> <p>Medication refrigerator temperatures are monitored. All medications are stored securely in line with legislation, protocols and guidelines. Review of the medication fridge evidenced that the service does not store or hold vaccines and interviews with the RN and the FM confirmed this.</p> <p>Medications are prescribed by the GP. The RNs administer pro re nata (PRN) medicines as prescribed and comments are made regarding effectiveness on the electronic medication record sighted. Current medication competencies were evident in staff files sampled where applicable. All RNs and ENs had completed syringe driver training. Observation of lunchtime medication administration evidenced alignment with legislation, protocols and guidelines.</p> <p>There were no residents self-administering medications at the time of the on-site audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of</p>	<p>FA</p>	<p>All meals are prepared on site. The seasonal menu, which has a four weekly cycle has been reviewed by a dietitian. The summer menu was being implemented at the time of audit. The food control plan was displayed and current. Current food management training and certificates for cooks and kitchen staff were sighted.</p> <p>Residents' dietary profiles are developed on admission and identify the residents' dietary requirements and preferences. The dietary profiles are communicated to the kitchen staff on admission to the facility and when a resident's dietary needs change. Diets are modified as needed and the cook interviewed confirmed awareness of the dietary needs of residents.</p>

<p>service delivery.</p>		<p>All food procurement, production, preparation, storage, delivery and disposal processes sighted and reviewed at the time of the audit meets the requirements of the standard. The cook is responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately in fridges, a freezer and a cool store. Temperatures of fridges, freezer and cool store are monitored and recorded daily. Dry food supplies are dated stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated. Food temperatures are monitored and documented.</p> <p>The lunchtime food service was observed. Residents were seen to be given time to eat their meal and assistance was provided when necessary. There were sufficient staff to ensure appropriate assistance was available. Residents and families interviewed stated that they were satisfied with the meals provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The residents' care plans are completed by the RN and based on assessed needs, desired outcomes and goals of residents. Care planning includes specific interventions for long-term and acute problems. The nursing progress notes and observations are recorded and maintained. Nursing interventions are reviewed within required timeframes and updated if there are changes in the health status of a resident.</p> <p>The DHB nurse practitioner for chronic health conditions visits regularly and provides support, advice and guidance to the facility manager and nursing staff. The GP documentation and records reviewed were current (refer to 1.3.3.3). Staff interviews confirmed they are familiar with the needs of all residents in the hospital and rest home and in the dementia unit.</p> <p>Family communication is recorded in the residents' files. Interviews with residents and families confirmed that care and treatment meet residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>There is an activities programme which considers the needs of residents at rest home, hospital and dementia levels of care. The activities programme is displayed in both service areas. A range of activities are planned which incorporate education, leisure cultural and community events. This includes, for example, quizzes, word games, newspaper readings, sports (bowls, balloon tennis), discussions, church services, school visits, outings and entertainment.</p> <p>The activities programme is implemented by an activities coordinator who works 8am to 3pm, Monday to Friday. A CG rostered on for the care of the three residents in the dementia unit also assists the activities coordinator with implementing activities. Weekend activities are implemented by CGs. Most activities take place in the dementia unit lounge to ensure all residents are able to attend. Records of attendance are maintained.</p> <p>Arrangements have been made for a diversional therapist from another UCG facility to begin visiting on a regular basis to oversee the programme, however, this was not in place at time of the audit.</p>



		<p>The residents' activities assessments are completed within three weeks of the residents' admission to the facility. Information on residents' interests, family and previous occupations are gathered during the interview with the resident and their family and are documented in the social profile.</p> <p>There is a 24-hour activity plan for the dementia level care residents with times of day when additional activities are required. Strategies are documented for managing individual residents with challenging behaviour and for providing activities of interest for the individual's well-being.</p> <p>The residents and their families reported satisfaction with the activities provided. During the on-site audit residents were observed engaging in a variety of activities in both the rest home/hospital and the dementia unit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>No formal six-monthly evaluations have occurred as the facility has not been open six months. There is evidence that long-term care plans are evaluated as the residents needs change. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Changes in the interventions are initiated when the desired goals/outcomes are not achieved. Residents and families interviewed confirmed notification of any changes. Contact with family was verified in the resident's records and documented on the family communication record in the individual resident files reviewed.</p> <p>Short-term care plans are developed for acute problems when needed and record goals and the required interventions for the identified short-term problems. The short-term care plans reviewed were signed, dated and closed out when the short-term problem had resolved.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated</p>	<p>FA</p>	<p>Current material safety data sheets are available and accessible to staff in relevant places in the facility (e.g. the sluice and cleaning cupboard). Staff receive training and education in waste management and infection control as a component of their orientation. The previous requirement for improvement relating to the availability of material data sheets has been closed.</p> <p>There is a sluice room for the disposal and rinsing of soiled equipment. The sluice room hoses have directional nozzles. The previous requirement for improvement relating to directional flow nozzles for hoses has been closed.</p> <p>Interviews and observations confirmed that there is enough personal protective clothing and equipment provided, such as aprons, gloves and masks. Interviews confirmed that the use of personal protective clothing and equipment is appropriate to the recognised risks. Observation confirmed that personal protective clothing and equipment is used in high-risk areas.</p>

during service delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>A current building warrant of fitness is displayed in the entrance to the facility. A current fire evacuation scheme is in place and a fire drill has been completed. However, not all firefighting equipment has evidence of a current check. The part of the previous requirement for improvement relating to evidence of a current check for all firefighting equipment remains open.</p> <p>A preventative and reactive maintenance schedule is implemented. The organisation has an annual test and tag programme, however, not all electrical equipment had evidence of a current test and tag.</p> <p>Equipment sighted appeared to have been purchased for the re-opening of the facility. However, there was no evidence of current checking or calibration to confirm that it was fit for purpose. The part of the previous requirement for improvement relating to evidence that equipment being fit for purpose remains open.</p> <p>There was sufficient equipment sighted to meet resident needs, including hoists, wheel chairs and walking frames. Observation confirmed consumables and signage are in place. The part of the previous requirement for improvement relating to equipment, signage and consumables being in place has been closed.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are sufficient accessible toilets and showering facilities of appropriate design to meet resident needs located in each area of the facility. The dual-purpose wing has rooms with a full ensuite and the remaining rooms have access to shared toilet and bathroom facilities. All bathroom facilities have functioning extractor fans, shower curtains, soap dispensers, paper towels and toilet paper. The previous requirement for improvement relating to bathroom facilities has been closed.</p> <p>Communal toilets have a system to indicate vacancy and have disability access. There are visitor toilets located at each end of the facility, one of which is in the dementia unit. All shower and toilet facilities have call bells; sufficient room; approved handrails; and other equipment to facilitate ease of mobility and independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are</p>	FA	<p>Residents have their own room, and each is of sufficient size to allow residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. Interviews with residents and family and observation confirmed that there was enough space to accommodate: personal items; furniture; equipment and staff as required.</p>

<p>provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>Residents and their families can personalise the resident's room. Furniture in residents' rooms include residents' own personal pieces and memorabilia; is appropriate to the setting and is arranged in a manner that enables residents to mobilise freely. There is one rest home only bed, in a room adjacent to the nurses' station. This was not occupied at the time of audit. Interview confirmed that this would only be used for a rest home level resident. This previous requirement for improvement is now closed.</p> <p>There are designated areas to store equipment such as wheel chairs, walking frames, commodes and hoists.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>PA Low</p>	<p>A cleaner is on duty each day, Monday to Friday. Cleaning over the weekend is completed by CGs when this is required. Cleaning duties and procedures are documented to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. The cleaner stores chemicals on a trolley when cleaning and keeps the trolley with them at all times. Staff receive training in correct use of cleaning products. There are designated cleaning cupboards for the safe and hygienic storage of cleaning equipment and chemicals in the kitchen and laundry. The part of the requirement for improvement relating to the storage of cleaning equipment and chemicals is closed.</p> <p>There are two designated laundry areas. However, the effectiveness of delineation requires review. The part of the previous requirement for improvement relating to delineation of clean and dirty areas in the laundry wash room, remains open.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is a civil defence plan/disaster plan specific to the facility and a suite of current and relevant emergency policies and procedures in place. The facility has sufficient current supplies, to sustain the facility in an emergency situation, such as emergency lighting, continence products, blankets and emergency water supplies.</p> <p>The previous requirements for improvement relating to currency of emergency policies and procedures; emergency supplies and water; has been closed.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate</p>	<p>FA</p>	<p>The facility is heated by wall panel heaters and heat pumps. The heat pumps are operational and the environment in all areas, was noted to be maintained at a satisfactory temperature for residents. On the days of the audit, the wall panel heaters were not switched on. The FM interview described systems that have been implemented to ensure that wall panel heaters do not exceed recommended safe temperatures when operational. The previous requirement for improvement relating to wall panel heaters being too hot to touch has been closed.</p>

<p>natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>Observation and interviews with residents and families confirmed that the environment was maintained at a comfortable temperature and there were no issues identified with the temperature of the facility.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>PA Low</p>	<p>The infection control policy identifies the requirements for the surveillance of infections. The type of surveillance and frequency is determined at a national level by UCG and is appropriate to the size and scope of Ultimate Care Palliser House.</p> <p>The designated infection control nurse is on long-term sick leave. The FM is the acting infection control nurse and currently responsible for surveillance activities. Both the infection control nurse and FM have completed training in infection control and certificates were sighted.</p> <p>Residents' files reviewed evidenced that those residents with an infection had a short-term care plan in place. The GP interviewed confirmed infections are reported in a timely manner. The RNs report infections on the designated form, however, infection control data was not always entered on the electronic system, with trends not identified or data analysed.</p> <p>In interviews care staff reported they are made aware of any infections through feedback from the RNs or the FM, verbal handovers, short-term care plans and progress notes. This was confirmed during attendance at the handover and review of the residents' files. The FM confirmed that there had been no outbreaks of infection at the facility since re-opening.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint minimisation and safe practice policies and procedures comply with legislative requirements.</p> <p>The restraint coordinator is the FM. A signed position description was sighted. The restraint register is maintained. There were no residents using restraints or enablers at the time of the on-site audit. Restraint minimisation and safe practice education is provided to all staff at orientation and induction to the service. The education and training programme included evidence of opportunities for annual ongoing education in relation to restraint (refer to 1.2.7.5). Interviews with staff confirmed knowledge and understanding of enabler and restraint use.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	<p>Residents and family confirmed that the FM and staff keep them informed on a one to one basis of facility activities and events. However, there are no formal regular processes in place, such as meetings; forums; or newsletter to advise residents and families of activities and events or for residents and family to have input into services.</p>	<p>Residents and their families do not have a platform for discussing concerns openly; such as regular structured resident/family meetings.</p>	<p>Ensure that formal ongoing communication forums, such as resident/family meetings, are available to residents and family.</p> <p>90 days</p>
<p>Criterion 1.2.3.4</p> <p>There is a document control system to manage the policies and procedures.</p>	PA Low	<p>There is a centrally managed organisational document data base that can be accessed via the UCG internal IT network. The UCG document control system ensures that policies and procedures are current.</p> <p>Each staff member has a manila folder with loose leafed human</p>	<p>Confidential documentation in individual staff files was</p>	<p>Ensure documentation in individual staff files is arranged</p>

<p>This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>		<p>resource information. The paperwork was not arranged in a logical sequence or secured within the folder and could easily fall out. One staff member's file reviewed contained confidential information relating to another staff member.</p>	<p>not arranged in a logical sequence or stored securely.</p>	<p>in a logical sequence and confidential staff information is held securely.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Low</p>	<p>There is policy that provides a procedure for staff to implement following a patient fall, that includes documentation of the incident/accident. Incidents/accidents are recorded in hardcopy. However, not all incidents/accidents are documented in line with policy into the electronic system.</p> <p>Policy and practice do not include the requirement for neurological observations, for the required timeframe following an unwitnessed fall. All falls are reviewed and reported as part of the quality improvement processes.</p> <p>Four of four incidents/accidents reviewed for patients experiencing an unwitnessed fall did not evidence that neurological observation had been completed or completed for less than four hours.</p>	<p>i) Not all adverse events had been documented in line with policy.</p> <p>ii) The falls policy does not outline the observations of a patient that are required following an unwitnessed fall, in line with best practice.</p> <p>ii) Neurological observations have not been completed for all patients experiencing an unwitnessed fall in line with best practice.</p>	<p>i) Ensure all adverse events are documented in line with policy.</p> <p>ii) Review the fall policy and revise to align with best practice, including the management of a patient and the required neurological observations following an unwitnessed fall.</p> <p>iii) Implement the revised policy and ensure neurological and other observations are completed according to best practice for patients experiencing an</p>

				unwitnessed fall.  90 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>The facility has implemented the UCG annual education and training plan. Training attendance records, training certificates and the annual training plan reviewed confirmed that all staff, including RNs have at least eight hours of relevant education and training hours planned to occur over 12 months.</p> <p>Training evidenced included: dementia, depression and delirium training; meaningful activities; incidents and accidents; and food safety. Staff working in the dementia unit have enrolled in the Careerforce dementia unit standard training. In addition, RNs had completed the DHB palliative care series of study days. Review of records and staff interviews confirm that staff have completed the planned training in the preceding three months. The annual training plan for the next 12 months includes topics such as care planning and behaviour that challenge. Registered nurses receive training at orientation on care planning.</p> <p>There was evidence of attendance records for some education sessions and some evidence of certificates of completion. However, attendance records are inconsistently maintained and the UCG electronic system for recording training is inconsistently updated.</p> <p>Two of five RNs did not have current first aid certificates. There were no CGs or ENs with current first aid certificates. Nine staff had been booked to undertake first aid training within two weeks following the on-site audit.</p>	<p>i) The centralised system to record and track ongoing training and competencies was not always updated.</p> <p>ii) Two RNs did not have current first aid certificates and no CGs or ENs had current first aid certificates.</p>	<p>i) Ensure the centralised system to record and track ongoing training and competencies is up to date.</p> <p>ii) Ensure that all staff involved with residential care have current first aid certificates.</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration,</p>	<p>PA Moderate</p>	<p>Medication is checked by the RN when received from the pharmacy. However, review of the drug register showed that drugs are not always checked weekly where required.</p> <p>A system is in place for returning expired or unwanted medication to the contracted pharmacy. However, observation identified medications that need to be used within a prescribed time once opened, were not</p>	<p>i) Weekly checks of drugs are not consistently completed where</p>	<p>i) Ensure that drugs are checked weekly and documented where required.</p> <p>ii) Ensure</p>

review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		always labelled with the date of opening or expiry date.	required. ii) Documentation of opening and expiry dates for medications that have to be used within a prescribed timeframe, are not always completed.	opening and expiry dates are documented for medications that have to be used within a prescribed timeframe.  60 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Initial assessments and initial care plans are completed on admission. However, two of five files reviewed evidenced that the resident had not had an initial medical assessment within five working days of admission.  InterRAI assessments are completed within three weeks of admission and serves as a basis for the long-term care plan. However, four of five resident files reviewed evidenced the long-term care plan had not been developed within the required timeframe following admission.	i) Not all residents were seen by a GP or NP within the required timeframes following admission.  ii) Long-term care plans were not consistently developed within three weeks of admission.	i) Ensure that all residents are seen by a GP or NP within the required timeframe following admission.  ii) Ensure that all long-term care plans are developed within three weeks of admission.  90 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain	PA Moderate	An activities programme is in place and implemented by an activities coordinator and CGs. Residents interviewed confirmed the activities provided are meaningful to them.  There is no evidence that a diversional therapist has overseen the	There is currently no oversight of the Ultimate	Ensure that a diversional therapist oversees the



strengths (skills, resources, and interests) that are meaningful to the consumer.		activity programme since Ultimate Care Palliser House opened. A plan is in place for a diversional therapist from another UCG facility to oversee the programme.	Care Palliser House activity programme by a diversional therapist.	activity programme at Ultimate Care Palliser House.  90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	A current fire evacuation scheme is in place and a fire drill has been completed. However, the fire blanket in the kitchen does not have evidence of a current test.  Observation identified equipment had been purchased for the re-opening of Ultimate Care Palliser House. However, there was no documentation to confirm that where appropriate, it had been checked or calibrated to verify it was fit for purpose.  An annual test and tag programme is in place, however, not all electrical equipment such as resident appliances, demonstrated evidence of a current test and tag.	i) Not all firefighting equipment demonstrated evidence of a current check.  ii) There was insufficient evidence that all equipment was fit for use.  ii) Not all electrical equipment had evidence of a current test and tag.	i) Ensure all firefighting equipment demonstrates evidence of a current check.  ii) Ensure that there is evidence that all equipment is fit for use.  ii) Ensure all electrical equipment has evidence of a current test and tag.  90 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 are two designated laundry areas, one at the end of the dementia wing and the other outside in close proximity to the laundry area in the dementia wing.  The room at the end of the dementia wing has key-pad entry and includes a washing machine and space for folding clothing. There is a line delineating the clean and dirty areas. Observation identified the clean area does not appear to be in use. However, to exit and enter	The line for delineation on the floor of one of the laundry areas requires staff to walk through the dirty area to	Ensure effective delineation of laundry areas.  90 days

		<p>the room requires walking through the dirty area, with clean linen.</p> <p>The outside room has a dryer and space for sorting, ironing and linen storage, that is used for clean laundry only.</p>	enter and exit the room.	
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	PA Low	<p>The RNs complete a form to report infections, for example, urine and respiratory infections. However, this data is not always entered electronically in the UCG reporting system to enable trending and specific recommendations to assist in achieving reductions in infection.</p>	<p>Not all infections are recorded on the electronic system and data is not always trended and analysed.</p>	<p>Ensure all infections are recorded on the electronic system and data is trended and analysed.</p> <p>180 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.