# The Ultimate Care Group Limited - Ultimate Care Allen Bryant

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

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| **Legal entity:** | The Ultimate Care Group Limited |
| **Premises audited:** | Ultimate Care Allen Bryant |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | Start date: 17 March 2020  End date: 18 March 2020 |

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 46

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| Indicator | Description | Definition |
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| <span style="color:blue">■</span> | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
| <span style="color:green">■</span> | No short falls | Standards applicable to this service fully attained |
| <span style="color:yellow">■</span> | 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 |
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| | 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

The Ultimate Care Group Limited - Ultimate Care Allen Bryant is part of the Ultimate Care Group. The facility is certified to provide services for 46 residents requiring rest home or hospital level care. There were 46 residents at the facility on the first day of audit.

This certification audit was conducted against the Health and Disability Service Standards and the facility's contract with the district health board.

The audit process included: review of policies and procedures; review of resident records and staff files; observations and interviews with family, management, staff, and a general practitioner.

Areas identified as requiring improvement at this audit relate to: care planning; wound care and compliance checks.

## Consumer rights

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

Information relating to the Health and Disability Commissioners' Code of Health and Disability Consumers' Rights; the complaints process; and the Health and Disability Advocacy Service is made available to residents and their families on admission and is accessible in the facility.

Staff interviews demonstrated an understanding of residents' rights, and their obligations to uphold those rights. Residents and family members confirmed their rights are being met.

Services are provided that respect the independence, personal privacy, individual needs, and dignity of residents. Residents were observed being treated in a professional and respectful manner.

Residents' cultural and spiritual beliefs are identified on admission. Cultural and spiritual support is available if required.

Policies are in place to ensure residents are free from discrimination, abuse and neglect.

Staff communicate with residents and family members following an accident/incident and this is recorded in the resident's file. Interviews with residents, family and the general practitioner confirmed that the environment is conducive to communication, that issues are identified where applicable, and that staff are respectful of residents' needs.

Informed consent is practised, and written consent is obtained when needed.

A documented complaints management system aligns with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. Complaints are investigated and documented, with corrective actions implemented where required.

## Organisational management

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| 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. | | Standards applicable to this service fully attained. |

The Ultimate Care Group is the governing body responsible for the services provided at this facility. The mission and values of the organisation are documented and communicated to all concerned.

The facility has implemented the Ultimate Care Group's quality and risk management system that supports the provision of clinical care and quality improvements. Meetings are held that include reporting on various clinical indicators, quality and risk issues, and discussion of identified trends.

The facility has an incident and accident management system to record and report adverse, unplanned or untoward events, including appropriate statutory and regulatory reporting.

The nurse manager is responsible for the overall management of the facility. The nurse manager, supported by a registered nurse team leader and registered nurses, is responsible for clinical management and oversight of services. Both the nurse manager and the team leader are registered nurses.

Human resource policies and procedures guide practice and there is evidence that human resource processes are being followed. There is a role specific orientation programme and ongoing training is provided. There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. Staffing levels are adequate across the services and meet contractual requirements.

Systems are in place to ensure the consumer information management system is protected from unauthorised access.

# Continuum of service delivery

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| 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. |

Registered nurses assess residents on admission. The initial care plan guides care and service provision during the first three weeks after admission.

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

Long-term care plans are developed and implemented within the required timeframes. Residents' files reviewed demonstrated evaluations were completed at least six-monthly. Residents and their relatives are involved in the care planning process and notified regarding any changes in a resident's health status.

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

There is an appropriate medication management system in place. Review of the electronic medication management system confirmed processes and practices are in line with the legislation and contractual requirements. Medications are administered by registered nurses and senior care givers who have completed medication competency requirements. Medicine management competencies reviewed for staff who administer medicines were current.

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

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

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

There are documented and implemented policies and procedures for waste management.

There is a current building warrant of fitness and an approved fire evacuation plan. Six-monthly trial evacuations are undertaken. Essential security systems are in place to ensure resident safety.

A planned, preventative and reactive maintenance programme is in place that includes equipment and electrical checks.

Residents' rooms provide single accommodation. Rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Shared bathroom and showering facilities are provided throughout the facility and are easily accessible. The facility has a monitored call bell system for residents to summon help when needed, in a timely manner.

There are documented and implemented policies and procedures for cleaning management. Cleaning and laundry services, provided seven days a week by household staff, are monitored.

## Restraint minimisation and safe practice

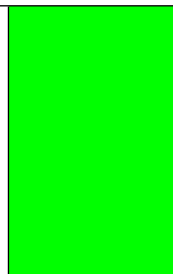| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the restraint coordinator who is a registered nurse. On the day of the on-site audit, the service had no restraints and two enablers in use. Restraint is only used as a last resort when all other options have been explored. Enablers are voluntary.

## Infection prevention and control

| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. | | Standards applicable to this service fully attained. |
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The infection control programme is appropriate to the size and complexity of the service. The infection control nurse is a registered nurse. Infection data is collated, analysed, trended and benchmarked. Monthly surveillance data is reported to staff and to the Ultimate Care Group national support office. There has been one outbreak since the previous audit which was reported and managed in accordance with policy.

# 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) |
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| Standards | 0 | 42 | 0 | 1 | 2 | 0 | 0 |
| Criteria | 0 | 90 | 0 | 1 | 2 | 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) |
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| 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 |
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| Standard 1.1.1: Consumer Rights During Service Delivery<br><br>Consumers receive services in accordance with consumer rights legislation. | FA | The organisation has implemented policies and procedures to ensure that services are provided in a manner that is consistent with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).<br><br>All staff have received education on the Code as part of orientation and the annual education programme. Staff interviews confirmed their understanding of the Code and described practices that evidence an understanding of their obligations. Evidence that the Code is implemented in their everyday practice includes but is not limited to: maintaining residents' privacy; providing residents with choice; involving family and residents in decision making; and ensuring residents are able to practise their own personal values and beliefs.<br><br>Resident and family interviews, as well as observation, confirmed that services are provided in a manner that upholds resident dignity and maintains their privacy. Staff are respectful towards residents and their families. Resident interviews confirmed they receive information relevant to their needs. |
| Standard 1.1.10: Informed Consent<br><br>Consumers and where | FA | There is an informed consent policy to ensure that a resident who has the capacity/competence to consent to a treatment or procedure, has been given sufficient information to enable a reasoned and voluntary decision. It provides guidelines for staff to ensure adherence to the legal and ethical |

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| appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | | requirements of informed consent and informed choice. The policy includes a definition of consent and procedures and how this will be facilitated and obtained.<br><br>Cultural considerations are identified such as whānau support and the involvement of whānau in decision making. The NM or RN discusses informed consent with family and the resident during the admission process to ensure understanding.<br><br>Staff receive orientation and training on informed consent and staff interviews confirmed they are aware of the informed consent process.<br><br>There is a resuscitation order and advance directives policy to ensure that the rights of the resident are respected and upheld, and residents are treated with dignity during all stages of serious illness. The policy defines the procedure for obtaining an advance directive and who may or may not make an advance directive. Resident record reviews demonstrated that advance directives and resuscitation orders were completed in accordance with policy. |
| Standard 1.1.11: Advocacy And Support<br><br>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | There is an advocacy policy for staff to follow, to ensure the Code is upheld and residents have facilitated access to representation and advocacy when needed.<br><br>Information regarding the availability of the Nationwide Health and Disability Advocacy Service is included in information packs provided to residents and family on admission to the facility. Additional advocacy services brochures are available at the entrance to the facility. The complaints policy also familiarises residents with their right to advocacy when making a complaint.<br><br>Interview with the NM confirmed that external advocacy services can be accessed if required. In addition, a pastor who visits the facility on most days, provides advocacy services for residents when needed. There is a separate resident meeting to the regular facility resident meetings chaired by an advocate about three times a year, where residents can raise any concerns or queries.  Any issues identified at this meeting are passed on to the NM and addressed through the quality management system.<br><br>Interviews with residents and family confirmed that they are aware of; the right to advocacy; and the availability of advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources<br><br>Consumers are able to maintain | FA | Observations and resident, family and staff interviews confirmed that families are welcome in the facility and were free to visit at any time. Residents, including YPD, have access to visitors of their choice.<br><br>The facility has implemented a connected community's initiative which fosters and encourages continued resident access and involvement within the community. It promotes attendance to local |

| links with their family/whānau and their community. | | events and performances, and access to local resources. Community involvement with the facility is also facilitated such as visits from local community groups and institutes. There are areas where a resident and family can meet in private. |
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| | | Interviews with residents, families and staff confirmed that residents are free to leave the facility in order to be involved in family events, attend afternoon teas, to visit local clubs or to go shopping. The activities programme includes outings in the community to places of interest such as church services, shopping and local gardens. |
| Standard 1.1.13: Complaints Management

The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The organisation has a complaints policy and process and flow chart to ensure that complaints are managed in line with Right 10 of the Code. The complaint process is made available as part of the admission pack and explained to the resident and family members by the NM on admission. The complaint forms are also available in resident areas in the facility.

Interviews with the NM, pastors, staff and residents confirmed that residents are encouraged to raise any concerns and to provide feedback on services. This includes discussing and explaining the complaints process. Resident and family interviews confirmed that they are aware of the complaints process. Residents and family stated that they had been able to raise any issues directly with the NM and that these are dealt with efficiently and to their satisfaction.

The NM is responsible for managing complaints. There had been 8 complaints over 2019 and 2020. An up-to-date complaints register is in place. Evidence relating to each lodged complaint and their resolution is recorded in the complaints' folder/register. Interview with the NM and a review of complaints indicated that complaints are investigated promptly and issues are resolved in a timely manner in line with the requirements of the Code.

There had been one external complaint in relation to a staff member. A copy of the complaint had been forwarded to UCG and investigated by UCG. No action was required of UCG as the matter was not related to service provision at Ultimate Care Allen Bryant. |
| Standard 1.1.2: Consumer Rights During Service Delivery

Consumers are informed of their rights. | FA | New residents and their families are given information about the Code as part the information provided on admission to the facility. This information and admission agreement include information on the complaints process and the advocacy service. Nurse manager (NM) resident and family interviews confirmed that the NM or a registered nurse (RN) explains the Code during the admission process to ensure understanding.

The Code, Nationwide Health and Disability Advocacy Service and associated information are available in information brochures which are displayed throughout the facility which can be taken away and read |

| | | in private. Information on the Code is also displayed in posters in English and te reo Māori within resident areas in the facility. |
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| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect<br><br>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The organisation has policies and procedures aligned to the requirements of the Privacy Act and Health Information Privacy Code to ensure that a resident's right to privacy and dignity is upheld. They provide staff with guidelines for respecting and maintaining residents' privacy and dignity.<br><br>Resident, family and staff interviews, as well as observation confirmed that: staff knock on bedroom and bathroom doors prior to entering rooms; staff ensured that doors were shut when personal cares were being provided; and residents were suitably attired when taken to the bathrooms. Privacy screens and curtains are fixed to the walls of the corridors at set intervals. Screens and curtains can be pulled across to section off parts of the corridors to enhance privacy when assisting residents to the bathrooms and when a staff member is in a resident's room providing personal cares. Interviews and observation confirmed that staff maintain confidentiality and were discrete, holding conversations of a personal nature in private. Residents' and family members' interviews confirmed that resident privacy is respected.<br><br>The organisation has a policy on sexuality and intimacy that provides guidelines for managing expressions of sexuality. Staff interviews confirmed that they assist residents to choose the clothing they wish to wear. Resident and family interviews and observation confirmed that residents could choose what clothing and adornments to wear each day, including makeup, if that was their preference.<br><br>Residents' files reviewed, staff, resident and family interviews and observation confirmed that individual cultural, religious and social preferences values and beliefs were identified, documented and upheld for all residents, including for younger persons with disabilities (YPD).<br><br>There is a policy which defines the guidelines and responsibilities of staff for reporting suspected abuse. It includes definitions of abuse and guidelines for managing abuse. Staff receive orientation and annual training on abuse and neglect. Staff interviews confirmed staff awareness of their obligations to report any incidences of suspected abuse or neglect. Staff, resident and family interviews stated that there was no evidence of abuse or neglect. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs<br><br>Consumers who identify as Māori have their health and disability needs met in a manner that | FA | The organisation has a Māori health plan that identifies how Ultimate Care Group (UCG) will respond to Māori cultural needs and Māori beliefs in relation to illness. Staff receive training in cultural safety and values at orientation and as part of the annual education programme.<br><br>Two residents identified as Māori at the time of the audit. Resident and family interviews stated that |

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| respects and acknowledges their individual and cultural, values and beliefs. | | they felt their cultural needs were met by the facility.

The NM interviewed reported that cultural advice for the facility and support for Māori families and residents is available through a local Māori health care provider if required.

Resident and family interviews advised that family have the opportunity to be involved in care planning and the delivery if they so wish. Staff interviews confirmed awareness of the importance of involving family/whānau in the delivery of care. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | There is a cultural safety policy which describes the procedure for identifying and meeting the cultural, physical, spiritual and psychological needs of the residents. It includes culturally sensitive considerations and practices.

Staff, resident and family interviews confirmed that residents are provided with choices regarding their care and the services offered, and that residents and family are involved in assessment and care planning processes.

Information gathered by staff during documented assessments includes identifying a resident's specific cultural needs, spiritual values, and beliefs. Assessments also involve obtaining background information on a resident's spiritual and cultural preferences, which includes, but is not limited to: beliefs; cultural identity; and spirituality. This information informs care planning and activities that are tailored to meet identified needs and preferences.

The cultural safety policy includes consideration of spiritual needs in care planning. For those residents who choose to attend, religious services are available weekly. Spiritual leaders are available to provide room blessings when required. |
| Standard 1.1.7: Discrimination

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | There are policies and processes to ensure that the environment for residents is free from discrimination, coercion, harassment, and financial exploitation. They provide guidance for staff on how this will be prevented and, where suspected, reported.

Job descriptions include the responsibilities of the position, including ethical issues relevant to each role. Staff interviews confirmed awareness of their obligation to report any evidence of discrimination, abuse and neglect, harassment and exploitation.

There were no documented complaints or incidents on record since the previous audit, relating to any form of discrimination, coercion or harassment.

On employment, staff are required to sign and abide by the UCG code of conduct and professional |

| | | boundaries agreement. Staff interviews confirmed their understanding of professional boundaries relevant to their respective roles. Interviews with residents and families confirmed that professional boundaries are maintained by staff. |
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| Standard 1.1.8: Good Practice<br><br>Consumers receive services of an appropriate standard. | FA | The facility implements the UCG policies and procedures, which are current and based on good practice and current legislation and guidelines. The policies align with the Health and Disability Services Standards and ensure safe, current evidence-based practice.<br><br>There are relevant training programmes for all staff.<br><br>Staff interviews, residents' progress notes and observation of service delivery confirmed that resident care was based on good practice guidelines. |
| Standard 1.1.9: Communication<br><br>Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The organisation has an open disclosure policy that promotes a transparent, consistent approach to full and open disclosure of actual or potential adverse events and/or harm during a resident's care. Completed accident/incident forms, residents' records and resident and family interviews demonstrated that family are always informed if the resident has an accident/incident, a change in health or a change in needs. Family contact is recorded on accident/incident forms and in residents' files.<br><br>The resident admission agreement signed by the resident or enduring power of attorney (EPOA) identifies what is, and what is not, included in the service provision.<br><br>Staff, resident and family interviews confirmed that family are included in resident care planning meetings. Three-monthly resident meetings inform residents and families of facility activities. All family are welcome to attend meetings. Meetings are advertised on the facility notice board and through personal reminders by staff. Meeting minutes, interviews and observation demonstrated regular attendance by residents and families. Meetings provide an opportunity to provide feedback and make suggestions for improvement, as well as to raise and discuss issues/concerns with management. Minutes of the resident meetings sighted provided evidence that there is free and frank discussion on a wide range of relevant subjects between stakeholders. Copies of the meeting minutes are available to residents on the notice board. Copies of the activities plan, and menu are also available to residents and families. Resident interview identified younger people with disabilities, have the opportunity to give input on new equipment purchases relevant to their needs.<br><br>Resident and family interviews confirmed that the NM and staff were approachable and available to discuss individual queries and issues. Interviews with residents and family identified that concerns and queries were addressed promptly and proactively. |

| | | There are policies to ensure that information is supplied in a way that is appropriate for the resident and/or their family. Interview with the NM confirmed that external interpreter services are available if required. At the time of the audit there were no residents who required an interpreter. |
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| Standard 1.2.1: Governance<br><br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | There is a quality and risk management document that outlines the mission and values, as well as detailing the business planning objectives of the organisation. The values and mission statement, which reflects a person/family centred approach, are displayed in the main corridor of the facility. The values and mission statement are communicated to all concerned through the facility's information pack provided to residents and family on admission. Staff receive this information at orientation.<br><br>The facility is part of the UCG, with the executive management team providing support to the facility. The facility NM reports to a regional manager, who is responsible for both regional quality and operational matters, with support from the UCG national quality manager on quality matters. Communication between the facility and UCG executive management occurs regularly. The UCG general manager clinical services, quality manager and two regional managers provided support during the audit.<br><br>The facility provides ongoing electronic reporting of events and occupancy into the UCGs national system that facilitates review of progress against identified indicators by the executive management team. This forms the basis of a monthly facility report. Monthly reports to the regional manager and national support office demonstrate monitoring of a range of performance indicators, including: admissions and discharges; staffing; compliments and complaints; infections; falls; weight loss and pressure injuries. Benchmarking against other UCG facilities occurs at a national level.<br><br>The facility is managed by a NM who is a RN and has been in this position for one year. The NM has over six years' previous management experience. The NM is responsible for both operational management and clinical care. The NM is supported in the oversight of clinical care by the RN team leader (TL). The TL provides clinical oversight on a day-to-day basis. The TL has been in the role for seven months and has ten years' RN experience. Both the NM and the TL have current practising certificates.<br><br>The facility is certified to provide rest home care and hospital level care for up to 46 residents. There were 46 beds occupied at the time of the audit, this included: 19 residents who had been assessed as requiring rest home level care and 27 residents assessed as requiring hospital level care. Included in the total occupancy numbers were three residents under the YPD contract, two of whom were under the age of 65 years. The three residents under the YPD contract were assessed as requiring hospital level care.<br><br>The facility has contracts with the district health board (DHB) for the provision of rest home and hospital |

| | | level care; respite care; chronic long-term conditions and an outcome agreement (YPD). Ultimate Care Allen Bryant does not have occupational right agreements. |
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| Standard 1.2.2: Service Management<br><br>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 NM, the TL with support from the Ultimate Care Allen Bryant operations coordinator and the regional manager, would be responsible for the day-to-day operation of the service. |
| Standard 1.2.3: Quality And Risk Management Systems<br><br>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The facility utilises the UCG's documented quality and risk management framework that is available to staff to guide service delivery. Policies and procedures align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. The UCGs management group reviews all policies with input from relevant personnel. Staff have electronic access to policies and procedures via the UCG internal network. New and revised policies are presented to staff and staff interviews confirmed that they are made aware of these.<br><br>Quality improvement, risk management, clinical indicators and corrective actions arising from quality improvement activities are discussed at monthly meetings. Meetings minutes evidenced that all aspects of: quality improvement; risk management; and clinical indicators are discussed. Copies of meeting minutes are available in the staff room for all staff to review.<br><br>The service delivery is monitored through the organisation's reporting systems utilising several clinical indicators such as: falls; infections; pressure injuries; skin tears; falls; and medication errors.<br><br>There was evidence that the annual internal audit programme is implemented as scheduled. Quality improvement data sighted provided evidenced that data is being collected and collated with the identification of trends and analysis of data. Corrective action plans are developed, implemented, evaluated and signed off where required. There is communication with staff of any subsequent changes to procedures and practice through monthly meetings.<br><br>Satisfaction surveys for residents and family are completed as part of the annual internal audit programme. Areas for improvement identified through surveys are implemented. Survey results evidenced satisfaction with the services provided. This was confirmed by residents' and family interviews. |

| | | The organisation has a risk management programme in place that records the management of risks in clinical, environment, and human resources. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Staff interviews confirmed an awareness of health and safety processes and described an environment that encouraged the reporting of hazards, accidents and incidents promptly. Health and safety events such as: incidents and accidents; hazard identification; emergency management; health and safety projects and initiatives; and staff education and orientation are discussed at health and safety meetings. Where required appropriate training or monitoring is undertaken to address health and safety events.

There are five health and safety representatives, representing most staff areas. Staff interviews and hazard reporting forms confirmed that hazard reporting occurs. There was evidence that identified hazards are addressed promptly and risks minimised. A current hazard register is available, and this is reviewed at least annually. |
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| Standard 1.2.4: Adverse Event Reporting

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. | FA | The NM and regional managers are aware of situations which require the facility to report and notify statutory authorities, including: unexpected deaths; police involvement; sentinel events; infectious disease outbreaks; and changes in key management roles. Management interviews confirmed that these would be reported to the appropriate authority by the UCG support office. Since the last audit, a norovirus outbreak has been reported to HealthCERT, the DHB and public health. The appointment of the NM has been reported to HealthCERT.

Interviews with staff and review of adverse event forms confirmed that all staff are encouraged to recognise and report adverse events. Staff interviews confirmed an understanding of the adverse event reporting process and their obligation to document all untoward events. A review of staff records demonstrated that staff receive education at orientation on the accident/incident reporting process.

There is an implemented accident/incident reporting process and incident/accident reporting forms are available on the notice board in the staff room. These are also available alongside resident/visitor information for residents and family to complete. Interviews with staff and review of documentation evidenced that staff document adverse, unplanned or untoward events on an accident/incident form which is reviewed and signed off by the NM or operations coordinator. These are entered onto the national incident reporting data base. Accident/incident reports selected for review evidenced that an appropriate assessment had been conducted and observations completed. There is evidence of a corresponding note in the resident's progress notes and notification of the resident's nominated next of kin where appropriate.

Information gathered is shared at monthly meetings with accidents/incidents graphed and trends analysed and discussed. Corrective actions arising from accidents/incidents were implemented for both |

| | | resident and staff accidents/incidents. Documentation including meeting minutes demonstrated actions were implemented and discussed. Specific learnings and results from accidents/incidents inform quality improvement processes and are regularly shared with staff at meetings. |
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| Standard 1.2.7: Human Resource Management<br><br>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position are documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; a signed employment agreement; position specific job description; current work visa and police vetting. There is evidence that relevant staff have additional role specific job descriptions, such as infection control coordinator, restraint coordinator, and health and safety representatives. A performance management process is in place and all staff files reviewed for staff employed longer that one year evidenced a current performance appraisal. New staff have completed an initial appraisal after three months.<br><br>There is a system to ensure that annual practising certificates and practitioners' certificates are current, including: RNs; physiotherapist; podiatrist; general practitioner (GP); pharmacists; and dietitian.<br><br>An orientation/induction programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency on a number of operational and care related tasks. Competencies such as medication, infection control, fire safety, manual handling, and hand hygiene are reviewed and assessed annually. Staff and manager interviews confirmed that new staff are supported during their orientation into their new roles until competent and confident.<br><br>A review of the management system confirmed that processes are in place to ensure that all staff complete their required training and competencies.<br><br>The organisation has implemented the nationwide, role specific annual education and training modules. An electronic database is used to record and track staff training/education. The electronic database and education session attendance records evidenced that ongoing education is provided, and staff have undertaken a minimum of eight hours of relevant training.<br><br>Four of seven RNs have completed interRAI assessments training and competencies. |
| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, appropriate, and safe service from | FA | The organisation's allocation of staff and duty roster policy requires a base roster to be set according to the needs of the different levels of care, individual need and resident numbers. Staff hours are required to be set to ensure that they are sufficient to provide safe care in a timely manner, taking into account dependency levels of residents and time required to provide care. A roster is developed, and reviewed to accommodate anticipated workloads, identified numbers of residents, and safe staffing levels within |

| suitably qualified/skilled and/or experienced service providers. | | the facility to meet the needs of residents' acuity and the minimum requirements of the DHB contract. Most staff are rostered on a four days on/two days off system. |
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| | | A hard copy roster is made available to staff one month in advance, as well as electronically through the electronic staff log in system. Staffing levels are reviewed daily. The electronic log in systems ensures staff are aware of any roster changes or updates. There are sufficient RNs and caregivers (CG) available to safely maintain the rosters for the provision of care to accommodate increases in workloads and acuity of residents. |
| | | The facility is made up of two main wings. One wing accommodates predominantly rest home residents and the second predominantly hospital level care residents. Each wing has a centrally located nurses' station. The NM and the TL are on morning shift duties from Monday to Friday. In addition there is at least one RN in each wing on morning and afternoon duty seven days per week. In the hospital wing, there are four CGs on each morning and afternoon shift. In the rest home, there are two CGs on each shift. In addition there is one CG on some shifts, noted on the roster as a 'floater', who works between the rest home and hospital wings. There is one RN and two experienced CGs on duty for the facility on each night duty. In the advent that additional RN support was required on the night duty, the NM or the TL are both on-call. |
| | | The NM and TL share on call after hours, seven days a week. The operations coordinator is also available on call for non-clinical operational matters. |
| | | Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy, as well as the requirements of the contract. |
| | | There are 53 staff, including: the NM; administration; clinical staff; activities coordinator; maintenance and household staff. Household staff include cleaners, laundry staff and kitchen staff who provide services seven day a week. |
| | | Observation of service delivery confirmed that residents' needs were being met in a timely manner. Family and resident interviews stated that staffing is adequate to meet the residents' needs. Staff interviews confirmed that whilst they are busy, they have sufficient time to complete their scheduled tasks and resident cares safely over their shift. |
| Standard 1.2.9: Consumer Information Management Systems<br><br>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and | FA | Residents' records are maintained in hardcopy with electronic medication charts in use. Residents' information, including progress notes, are legible and entered into the resident's record in an accurate and timely manner, identifying the name and designation of the person making the entry. Residents' progress notes are completed every shift, detailing resident response to service provision. |
| | | There are policies and procedures in place to ensure the privacy and confidentiality of resident |

| accessible when required. | | information. Staff interviews confirmed an awareness of their obligations and the procedures for maintaining confidentiality of resident information. Resident care and support information can be accessed in a timely manner and is protected from unauthorised access by being locked away when not in use. Archived records are securely stored on-site in a secure container. Archived records can be retrieved if required. Observation confirmed documentation containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. |
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| | | Each resident's information is maintained in an individual, uniquely identifiable record. Records include information obtained on admission, with input from the resident's family and resident where applicable. |
| | | The resident records reviewed were integrated, including information such as medical notes, assessment information and reports from other health professionals. Electronic medication charts are kept separate from residents' files and are accessible by authorised personnel only. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The needs assessment and service coordination (NASC) assessments are completed for entry to the service and kept in the resident's record. All resident records reviewed had current interRAI assessments in place. There is an information pack provided to all residents and their families prior to admission. Review of residents' records confirmed entry to service complied with entry criteria. Interviews with residents and families and review of records confirmed the admission process was completed in a timely manner. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Transition, exit, discharge, or transfer is managed in a planned and coordinated manner. Interviews with RNs and review of residents' records confirmed there is open communication between services, the resident, and the family/whānau. Relevant information is documented and communicated to health providers. A transfer form accompanies residents when a patient is moved to another service or facility. Follow-up occurs to check that the resident is settled. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice | FA | The medication management system is documented and implemented and complies with legislation, protocol and guidelines. An electronic medication system is used. Prescribing practices are in line with legislation, protocols and guidelines. The required three-monthly reviews by the GP were recorded electronically. The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. Weekly checks and six-monthly |

| | | stocktakes of drugs are conducted and confirmed that stock matched expected levels. Pharmacy input was verified. Medications were observed to be stored appropriately. There are no standing orders used at the facility. |
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| | | The medication refrigerator temperatures are monitored daily. Review of the medication fridge evidenced that the service does not store or hold vaccines and interviews with the RN confirmed this. |
| | | The staff observed administering medication demonstrated knowledge and had a clear understanding of their roles and responsibilities related to each stage of medication management. Staff observed complied with the medicine administration policies and procedures. Current medication competencies were evident in staff files. |
| | | There were two residents self-administering medication during the on-site audit. A process is in place to ensure ongoing competency of the residents and this is authorised by the GP. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals are prepared on site. The seasonal menu has been reviewed by a dietitian. |
| | | A nutritional assessment is undertaken for each resident on admission by a RN to identify the residents' dietary requirements and preferences. The dietary profiles are communicated to the kitchen staff and updated when a resident's dietary needs change and when dietary profiles are reviewed six-monthly. Diets are modified as needed and the cook interviewed confirmed awareness of the dietary needs, likes and dislikes of residents. These are accommodated in daily meal planning. Supplements are provided to residents with identified weight loss problems as medically required. |
| | | Residents were seen to be given enough time to eat their meal and assistance was provided when necessary. There were enough staff to ensure appropriate assistance was available. Residents and families interviewed stated that they were satisfied with the meals provided |
| | | The facility has a current food control plan. |
| | | All aspects of food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit comply with current legislation and guidelines. The cook is responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately in fridges, a freezer and cool store. Temperatures of fridges and the freezer are monitored and recorded daily. Dry food supplies are stored in the pantry and rotation of stock occurs. Dry stock containers sighted were labelled and dated. Food temperatures are monitored appropriately and recorded daily. |
| | | The kitchen was observed to be clean and cleaning schedules were sighted. |
| | | All kitchen staff files evidenced they had relevant food hygiene and infection control training. . |

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| Standard 1.3.2: Declining Referral/Entry To Services<br><br>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service has a documented process in place should access be declined. When residents are declined access to the service, residents and their family/whānau, the referring agency and/or GP are informed of reasons for this. The resident would be declined entry if not within the scope of the service or if a bed was not available. Interview with the NM identified that a waiting list is maintained. |
| Standard 1.3.4: Assessment<br><br>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The initial nursing assessment and the initial care plan are completed within 24 hours of admission. The initial care plan guides care for the first three weeks. Registered nurses complete the interRAI assessment within the required timeframes. The long-term care plan is based on the interRAI assessment outcomes. Assessments are recorded and reflect data from a range of sources, including: the resident; family/whānau; the GP and specialists.<br><br>Policies and protocols are in place to ensure continuity of service delivery. Assessment tools are reviewed at least six-monthly, including falls, dietary, pressure injury and continence. Interviews with residents and families confirmed their involvement in the assessments. |
| Standard 1.3.5: Planning<br><br>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | Long-term care plans are developed with the resident and family/whānau involvement. All residents' files sampled had an individualised long-term care plan. However, long-term care plans did not always include all interventions required to meet all assessed resident needs.<br><br>Short-term care plans are developed for the management of some acute problems, however; short-term care plans were not developed for all residents who had an infection.<br><br>Resident files showed service integration with clinical records, activities notes, and medical and allied health professionals' notes and letters. Interviews with residents confirmed they have input into their care planning and review, and that the care provided meets their needs.<br><br>Review of residents' records showed that the residents under the YPD contact are involved in care planning. Their plans included activities to ensure their wellbeing, community participation and interventions to meet their physical, health and wellbeing needs. |
| Standard 1.3.6: Service | PA | Long-term care plans are completed by the RN and based on assessed needs, desired outcomes and goals of residents. When documented, interventions are reviewed within required timeframes (refer to |

| Delivery/Interventions | Moderate | 1.3.5.2). However, assessment, care and evaluation of wounds do not comply with best practice. |
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| Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | | The GP documentation and records reviewed were current. Interviews with residents and families confirmed that care and treatment met residents' needs. Staff interviews confirmed they are familiar with the needs of all residents in the facility. Family communication is recorded in the residents' files. Nursing progress notes and observations are recorded and maintained. |
| Standard 1.3.7: Planned Activities | FA | The residents' activities programme is implemented by the activities coordinator. Activities for the residents are provided five days a week, Monday to Friday. The activities programme was displayed on the resident noticeboards. The activities programme provides variety in the content and incorporates education, leisure, cultural, spiritual and community events. Regular van outings into the community are arranged. |
| 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. | | The residents under the YPD contract confirmed that they were satisfied with the activities provided, for example the visits to the gym twice weekly and the outings to maintain their community links. |
| | | The residents' activities assessments are completed within three weeks of the residents' admission to the facility in conjunction with the admitting RN. Information on residents' interests, family and previous occupations are gathered during the interview with the resident and their family and documented. The residents' activity needs are reviewed six-monthly at the same time as long-term care plans and form part of the formal six-monthly multidisciplinary review process. |
| | | The residents and their families reported satisfaction with the activities provided. Over the course of the audit, residents were observed engaging and enjoying a variety of activities. |
| Standard 1.3.8: Evaluation | FA | Resident care is evaluated on each shift and reported at handover and in the progress notes (refer 1.3.6.1). If any change is noted, it is reported to the RN. |
| Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | | Long-term care plans are evaluated every six months in conjunction with the interRAI re-assessments or if there is a change in the resident's condition. Evaluations are documented by the RN. The evaluations include the degree of achievement towards meeting desired goals and outcomes (refer to 1.3.5.2). |
| | | Residents and families interviewed confirmed involvement in the evaluation process and any resulting service delivery changes. Contact with family was verified in the resident's progress notes and documented on the family communication record in the individual resident records reviewed. |

| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)<br><br>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other medical and non-medical services. Where needed, referrals are sent to ensure other health services, including specialist care, is provided for the resident. Referral forms and documentation are maintained on resident files. Referrals are regularly followed up. Communication records reviewed in the residents' files, confirmed family/whānau are kept informed of the referral process. |
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| Standard 1.4.1: Management Of Waste And Hazardous Substances<br><br>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented policies and procedures for the management of waste and hazardous substances are in place. Policies and procedures specify safety requirements that comply with legislation, including the requirements for labelling, collecting, and disposing of waste. The hazard register is available and current.  The facility has a current hazardous substance certificate as sighted on the on-site audit.<br><br>Current material safety data posters are available and accessible to staff in relevant places in the facility as observed during on-site audit. The product supplier provides online training in the safe use of chemicals. Where required, one-on-one training is provided to individual staff members.<br><br>Staff receive training and education in waste management and infection control as a component of orientation and mandatory training.<br><br>Manager and staff interviews as well as 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 was used in high-risk areas. |
| Standard 1.4.2: Facility Specifications<br><br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | A current building warrant of fitness is displayed in the entrance to the facility.<br><br>There is a preventative and reactive maintenance schedule. This includes a process to complete monthly maintenance checks of areas and specified equipment, however, not all areas and equipment on the schedule demonstrated a documented monthly check.<br><br>Staff raise issues directly or identify maintenance issues in one of two maintenance log books. These are reviewed by the maintenance person when at the facility or when called typically within two to three days.  A review of maintenance requests and interviews confirmed staff awareness of the processes for maintenance requests. Where urgent repairs were required, the maintenance person would be called in or the UCG help line would be contacted. The implementation of maintenance and repair requests are |

| | | monitored electronically through the UCG national system. There was evidence that urgent repairs and maintenance were completed in a timely manner. |
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| | | Interviews with staff and visual inspection confirmed there is adequate equipment available to support care. The facility has an annual test and tag programme that is up to date. Evidence of checking and calibration of biomedical equipment was sighted. |
| | | The facility van used for resident outings is checked and cleaned by the maintenance person. However, there was no record that the van driver had completed annual competency assessments for van driving or for the use of the van hoist. |
| | | Hot water assaying is monitored as part of the internal audit schedule. Hot water temperatures are assayed monthly. Where temperatures exceeded the recommended 45 degrees, records of rechecking the temperature following corrective action were not maintained. |
| | | All resident areas inspected can be accessed with mobility aides. There are two outdoor courtyards with seating and shade that can be accessed freely by residents and their visitors. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities<br><br>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. | FA | There are sufficient accessible toilets and showering facilities of appropriate design to meet residents' needs located in each area of the facility. In the hospital wing, there are two sets of two rooms with shared ensuites between two rooms.  All other residents, including those in the rest home wing, have access to shared toilet and bathroom facilities.<br><br>Toilets have a system to indicate vacancy, as well as signage and disability access. There are two centrally located visitors' toilets. Shower and toilet facilities all have: call bells; sufficient room; approved handrails; and other equipment to facilitate ease of mobility and independence.<br><br>Residents were observed being supported to access communal showers in a manner that was respectful and preserved their dignity. |
| Standard 1.4.4: Personal Space/Bed Areas<br><br>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All residents' bedrooms are single rooms. Each is of sufficient size to allow residents to mobilise freely and safely around their personal space and bed area, including with mobility aids and assistance. Interviews with residents and family, as well as observation, confirmed there was enough space to accommodate: personal items; furniture; equipment, and assisting staff as required.<br><br>Residents and their families can personalise the residents' rooms with the residents' own personal pieces and memorabilia.<br><br>There are designated areas to tidily store equipment such as wheelchairs, walking frames, and hoists. |

| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining<br><br>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a dining room and adjoining lounge in the rest home wing, and a combined lounge/dining room in the hospital wing. Residents were observed to have their meals with other residents in the communal dining rooms.<br><br>All internal communal areas have seating and external views. Areas can be easily accessed by residents, family and staff. There are areas, including a whānau /family room, available for residents, including YPD, to access with their visitors for privacy if they wish. Observation and interviews with residents and family confirmed that residents can move freely around the facility and that the accommodation meets residents' needs.<br><br>There are areas for storing activities equipment and resources. |
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| Standard 1.4.6: Cleaning And Laundry Services<br><br>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The effectiveness of cleaning and laundry processes are monitored through the internal audit process with no significant problems identified. Resident and family interviewed stated facility cleaning was spotless and to a high standard. Resident surveys and observation noted the facility to be clean and tidy.<br><br>The facility has household staff members on morning shift, seven days per week. Interviews and observation confirmed that staff worked in their specified role and did not assist with other duties such as food service.<br><br>Facility laundry, including residents' personal labelled clothing, is completed on site. There is one laundry staff member on Monday through to Saturday inclusive. The laundry was observed to be clean and well organised. Colour coded, covered laundry trolleys and bags were observed to be used for transport. Staff interviews confirmed an understanding of their role including management of any infectious linen. There is clear delineation and observation of clean and dirty areas in the laundry. Staff, resident and family interviews and complaint forms confirmed that there were no issues relating to missing residents clothing. Residents and family interviews identified that their laundry was managed to a high standard and met their requirements.<br><br>There are two cleaners, one allocated to each wing, on duty Monday through to Friday. On the weekends there is one cleaner for the whole facility. 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 cleaners store chemicals on a trolley when cleaning, and are aware of the need to keep the trolley with them at all times. Staff receive training in correct use of cleaning products. |

| | | Hand washing facilities are available throughout the facility with alcohol gels in various locations. |
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| Standard 1.4.7: Essential, Emergency, And Security Systems<br><br>Consumers receive an appropriate and timely response during emergency and security situations. | FA | An approved fire evacuation plan was sighted. Fire drills are conducted at least six-monthly. A staged evacuation attended by New Zealand fire service is alternated with a full staff evacuation. There is a sprinkler system installed throughout the facility and exit signage displayed. Training records confirmed that staff have undertaken fire training. An RN is the nominated fire warden on each shift.<br><br>Records and interviews evidenced that sufficient staff have current first aid certificates. This includes all RNs and the activities coordinator. There is at least one staff member on each shift who has a current first aid certificate.<br><br>The facility has sufficient supplies to sustain staff and residents in an emergency situation. Alternative energy and utility sources are available in the event of the main supplies failing. These include: a generator; a barbeque; torches; and enough food; water; and continence supplies. Emergency supplies are checked monthly. There is generator powered emergency lighting. The service's emergency plan showed considerations of all levels of resident need.<br><br>Call bells are available to summon assistance in all residents' rooms and bathrooms. Call bells are checked monthly by the maintenance person. Observation and family interviews confirmed that call bells are answered promptly.<br><br>Security systems are in place to ensure the protection and safety of residents, visitors and staff. These include: visitors signing in and out of the building; the facility being locked in the evenings with restricted entry through ringing a call bell at the front entrance after hours; security lighting and night security checks undertaken by staff. The NM interview advised that in the event of a security breach, the local police who are located close to the facility would be called. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating<br><br>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents' rooms and communal areas accessed by residents have safe ventilation and at least one external window providing natural light. The facility is heated by heat pumps and ceiling heaters. There are systems in place to obtain feedback on the comfort and temperature of the environment, for example, residents meetings and surveys. Residents are able to control the temperature thermostat in their own room to suit their personal requirements. The temperature of facility communal areas is monitored and reported. 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.<br><br>The facility has a designated external smoking area. At the time of the audit there were two residents |

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| Standard 3.1: Infection control management<br><br>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 | Ultimate Care Allen Bryant provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an infection prevention and control programme. An RN is the infection control nurse (ICN) and has access to external specialist advice from the DHB infection control specialists, and microbiologists when required. A documented role description for the ICN, including role and responsibilities, is in place.<br><br>The annually reviewed infection control programme is appropriate for the size and complexity of the service.<br><br>Staff are made aware of new infections through daily handovers on each shift, progress notes and clinical records, however; not all residents with an infection had a short-term care plan in place (refer finding 1.3.5.2). There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff, residents, and visitors to use. |
| Standard 3.2: Implementing the infection control programme<br><br>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICN is responsible for implementing the infection control programme.<br><br>The ICN stated that there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the facility's meetings. The ICN has access to all relevant resident data to undertake surveillance, internal audits, and investigations. Staff interviewed demonstrated an understanding of the infection prevention and control programme. |
| Standard 3.3: Policies and procedures<br><br>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures | FA | The Ultimate Care Group has documented policies and procedures in place that reflect current best practice and legislation relating to infection prevention and control.<br><br>Staff were observed to be complying with the infection control policies and procedures. Staff demonstrated knowledge, including but not limited to, the requirements of standard precautions and were able to locate infection prevention and control policies and procedures. |

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| are practical, safe, and appropriate/suitable for the type of service provided. | | |
| Standard 3.4: Education<br><br>The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Staff education on infection prevention and control is provided by the ICN and external infection control specialists. All staff attend infection prevention and control training. Records of attendance are maintained. Staff interviewed confirmed their understanding of how to implement infection prevention and control activities into their practice.<br><br>Resident education occurs as required on a one-on-one basis. |
| Standard 3.5: Surveillance<br><br>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The UCG surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring.<br><br>Internal infection prevention and control audits are completed. Infection data is collated monthly by the nurse manager and is submitted to UCG national support office. Monthly surveillance data is collated and analysed to identify any trends, possible aetiology and any required actions. This data is reported at the monthly infection control meeting and at the monthly staff and quality meeting.<br><br>Interview with the ICN confirmed there has been one outbreak (norovirus in February 2020) since the previous audit. Documentation reviewed and interview with the GP confirmed that this had been managed in accordance with policy and resolved within two weeks. |
| Standard 2.1.1: Restraint minimisation<br><br>Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers.<br><br>The restraint coordinator is an RN and they provide support and oversight for enabler and restraint management in the facility. The coordinator is new to the role and is conversant with restraint policies and procedures. Online training has been arranged via the DHB.<br><br>On the day of the audit, no residents were using restraints and two residents were using enablers, one bedrail and one lap belt, which were the least restrictive measures and used voluntarily at their request as documented in the residents' records. A similar process is followed for the use of enablers as is used for any restraint use.<br><br>Restraint is used as a last resort when all alternatives have been explored. This was evident from interviews with staff who are actively involved in the ongoing process of minimisation. Regular training occurs and review of restraint and enabler use is completed and discussed at quality meetings. |

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# Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| Criterion 1.3.5.2<br><br>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | The progress notes of residents with infections contained information about interventions and ongoing evaluation of the infection. However, in three of the five resident records reviewed there was no short-term care plan developed to guide resident care relating to the infection.<br><br>All residents had a long-term care plan developed by an RN with input from residents and family as appropriate. In five of eight files reviewed, long-term care plans did not contain interventions for management of high falls risk, management of seizures and management of residents who were known to show resistance to cares. | i) Short-term care plans are not in place to guide care for all residents with infections.<br><br>ii) Interventions in the long-term care plans were not documented for all assessed resident | i) Ensure that a short-term care plan is in place for each resident with an infection.<br><br>ii) Ensure all long-term care plans include for interventions to meet all assessed resident needs. |

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| | | | needs. | 90 days |
| Criterion 1.3.6.1<br><br>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA<br>Moderate | There is a record kept of all wounds in the facility and there is an adequate supply of wound care products available. The UCG wound care policy is in line with best practice and guides staff to complete assessment, treatment plans and evaluation of progress of wounds. However, 10 of 10 wound care plans reviewed did not have all components of documentation in line with the UCG policy or best practice. | Assessment, treatment plans and evaluation of wounds do not comply with best practice. | Ensure that all wound care documentation including assessment, treatment plans and evaluation complies best practice.<br><br>90 days |
| Criterion 1.4.2.1<br><br>All buildings, plant, and equipment comply with legislation. | PA<br>Moderate | The facility has a documented preventative and reactive maintenance schedule, inclusive of monthly maintenance checks for equipment and areas such as emergency exits, call bells and specified equipment. The maintenance person was not available for interview during the time of the audit. A review of maintenance records did not provide sufficient evidence to provide assurance that all areas on the schedule were checked monthly.<br><br>A national call up system is in place to ensure that the van used for residents' outings used for resident outings has a current registration, warrant of fitness, vehicle servicing and serviceable hoist. Safety/serviceability checks are undertaken and include for example: warrant of fitness; registration; tyres; water; and oil. However, records did not confirm that these checks are completed consistently as scheduled on the monthly maintenance plan.<br><br>The van is driven by the activities coordinator. Interviews with staff and documentation evidenced that the staff member who drives the van has a current driver's licence. However, there is no record of an annual driving skill competency assessments having been undertaken for the van driver or a for the use of the van hoist.<br><br>There is system to monitor and assay hot water temperatures monthly to ensure these are maintained within recommended temperature ranges. A review of | i) Maintenance records did not provide sufficient evidence that all areas on the monthly maintenance schedule were checked as required.<br><br>ii) Records do not demonstrate that van driving and van hoist competencies have been | i) Ensure records are maintained that evidence the implementation of the monthly maintenance programme.<br><br>ii) Ensure van driving and van hoist competencies have been completed annually for those who drive the van.<br><br>iii) Hot water temperatures are maintained |

| | | temperature assays and interview with the NM confirmed that where hot water temperatures have been above the recommended 45 degrees, immediate action is taken to bring the temperature into a safe range. Interview identified that rechecking of the temperature occurs until assurance that a safe temperature is being maintained. However, records were not maintained to confirm that when temperatures at the faucet exceeded the recommended 45 degrees, that temperatures have then been reduced and maintained at a safe temperature following actions taken. | completed annually for those who drive the van.<br><br>iii) Records do not evidence hot water temperatures are consistently maintained below a safe 45 degrees. | consistently below a safe 45 degrees and this is evidenced in rechecks of temperatures.<br><br>60 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.