

The Ultimate Care Group Limited - Ultimate Care Poneke House

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:

Legal entity:	The Ultimate Care Group Limited
Premises audited:	Ultimate Care Poneke House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 7 July 2020 End date: 8 July 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:	45

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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 Pōneke House is part of the Ultimate Care Group. The facility is certified to provide services for 50 residents requiring rest home, hospital or dementia level care. There were 45 residents at the facility on the first day of audit.

This surveillance 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; interviews with residents and family, management, staff, and a general practitioner.

Areas identified as requiring improvement at this audit relate to: complaints management, quality improvement, adverse events, human resource management, service provision timeframes; interventions, medication management, food, fluid and nutritional needs, and physical environment.

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

A documented complaints management policy aligns with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. 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.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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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 is currently being managed by an organisation relief manager, who is responsible for the overall management of the facility. A clinical manager, supported by registered nurses, is responsible for the oversight of clinical service provision. The clinical manager is a registered nurse and holds a current practicing certificate. The facility management team is supported by the regional operations manager.

The facility has implemented the Ultimate Care Group's quality and risk management system that supports the provision of clinical care. Quality and risk performance are monitored through the organisation's reporting systems. An internal audit programme is implemented.

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

Human resource policies and procedures guide practice. 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.

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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Residents' initial care plans are completed within the required timeframe to guide care and service provision during the first three weeks post the resident's admission. The general practitioner completes an initial medical assessment on the resident's admission.

The residents' files demonstrated care plan evaluations were completed at least six-monthly. The 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.

The activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

The electronic medication management system is in place and medications are administered by clinical staff who have completed medication competency requirements.

Meals are prepared on-site and follow dietitian approved menus. The service has a food control plan which is current.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is a current building warrant of fitness and an approved fire evacuation plan. There have been no structural alterations undertaken since the previous audit.

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 one resident using restraint and no residents requesting the use of enablers.

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 prevention and control programme is appropriate to the size and complexity of the service. Infection data is collated, analysed, trended and benchmarked. Monthly surveillance data is reported to staff and to the Ultimate Care Group National Support Office.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	7	0	4	5	0	0
Criteria	0	29	0	7	5	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>The organisation has a complaints policy and process in place. The complaint process is made available and explained to the resident and family on admission. The complaint forms are also available in resident areas in the facility. Resident and family interviews confirmed that they are aware of the complaints process.</p> <p>The facility manager is responsible for managing complaints. A complaints register is in place, however not all complaints are documented in the register. Evidence relating to some, but not all, lodged complaints is held in the complaints folder and entered onto the register. Interview with the interim manager and a review of complaints indicated that the two most recent complaints had been investigated promptly, and issues are resolved in a timely manner in line with the requirements of the Code.</p> <p>Residents and family stated that they had been able to raise any issues directly with the CM.</p> <p>The regional manager and CM advised that they were not aware of any complaints made to external agencies since the last audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<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 a resident's care. Incident and residents' records and resident and family interviews demonstrated that family are informed if the resident has an accident/incident; a change in health or a change in needs. Family contact</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>is recorded on the electronic incident form and in the resident's file.</p> <p>The resident admission agreement signed by the resident or enduring power of attorney (EPOA), confirms for residents what is and what is not included in service provision (refer to 1.3.3.3).</p> <p>Staff, resident and family interviews confirmed that family are included in resident care planning meetings. The two monthly resident meetings inform residents and families of facility activities. All family are welcome to attend meetings. Meeting minutes demonstrate regular attendance by residents and families. Meetings provide residents and family with an opportunity to provide feedback and make suggestions for improvement as well as raise and discuss issues or concerns. Minutes of the resident meetings sighted evidenced that a range of relevant subjects are discussed. The diversional therapist provides copies of the meeting minutes to residents who wish to receive these. Copies of the activities plan, and menu are also available to residents and families.</p> <p>Resident and family interviews confirmed that the clinical manager (CM) and staff were approachable and available to discuss queries and issues. Interviews with residents and family identified that the CM addressed concerns and queries promptly and proactively.</p> <p>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 relief facility manager and regional manager confirmed that staff or family were available to provide interpreter services if required and external interpreter services were available through the district health board (DHB). At the time of the audit there were two residents who required the assistance of an interpreter and a staff member was available to provide this service.</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>	<p>FA</p>	<p>There is a quality and risk management document that outlines the organisation's mission and values as well as detailing the business planning objectives of the organisation. The values and mission statement 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.</p> <p>The facility is part of the Ultimate Care Group (UCG) with the executive management team providing support to the facility. The facility manager reports to a regional manager, with support from the regional clinical lead and wider UCG executive management. Communication between the facility and the UCG executive management occurs regularly with the facility's regional manager providing support during the audit.</p> <p>The facility provides ongoing electronic reporting of events and occupancy into the UCG's 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 office demonstrated that a range of performance indicators are monitored including: admissions and discharges; staffing; compliments and complaints, infections; falls; weight loss and pressure injuries.</p>

		<p>The current facility manager has been in the role for just over one year and has two-years previous experience as a manager at another UCG facility. The current facility manager was on leave at the time of the audit. A relieving manager has been covering for this leave since 15 June 2020. The relieving manager has seven years' experience as a roving manager with UCG and is a registered nurse (RN) with a current practicing certificate.</p> <p>The facility manager is supported by a CM who has been in this position for over one year. The CM is a RN with a current practicing certificate and has three years' experience with the organisation including experience as a CM at another UCG facility. The CM is supported by a team of RNs.</p> <p>The facility is certified to provide rest home care, hospital and dementia level care for up to 50 residents (reported previously in certification reports as 49 beds, since the partial provisional audit was conducted in 2017). There were 45 beds occupied at the time of the audit, this included: 15 residents who had been assessed as requiring rest home level care; 14 assessed as requiring hospital level care and 16 assessed as requiring dementia level care. Included in the total occupancy numbers were two residents who were under the age of 65 years, under the chronic long-term conditions agreement who were assessed as requiring hospital level care.</p> <p>The facility has contracts with the DHB for the provision of rest home, hospital level care; and dementia level care, respite care; chronic long-term conditions agreement; day care. At the time of the audit there was one resident receiving care under the day care contract and no residents receiving care under the respite contract.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>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 UCG's management group reviews all policies with input from relevant personnel. Staff have electronic access to policies and procedures via the UCGs internal network. New and revised policies are presented to staff and staff interviews confirmed that they are made aware of these.</p> <p>Quality improvement, risk management, clinical indicators and corrective actions arising from quality improvement activities are discussed at monthly meetings. Meetings minutes evidenced that: quality improvement; risk management; and clinical indicators are discussed. Copies of meeting minutes are available in the staff room for all staff to review.</p> <p>The service delivery is monitored through the organisation's reporting systems utilising several clinical indicators such as: falls; infections; pressure injuries; skin tears; infections; falls; and medication errors.</p> <p>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</p>

		<p>where required. There is communication with staff of any subsequent changes to procedures and practice through staff meetings. Although implementation was not consistently evidenced in meeting minutes.</p> <p>Satisfaction surveys for residents and family are completed as part of the annual internal audit programme. Areas for improvement identified through surveys are implemented and discussed at staff meetings. Survey results evidenced satisfaction with the services provided. This was confirmed by residents' and family interviews.</p> <p>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, including the reporting of hazards, accidents and incidents promptly. Health and safety events such as: incidents and accidents; hazard identification; emergency management including Covid-19 updates and requirements; and staff education are discussed at staff and health and safety meetings.</p> <p>Health and safety systems are implemented. Staff interview confirmed that hazard reporting occurs. There was evidence that identified hazards are addressed and risks minimised.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Low</p>	<p>The relief facility manager and the regional manager are aware of situations which require the facility to report and notify statutory authorities. Interviews and documentation confirmed that these are reported to the appropriate authority by the UCG support office. Since the last audit: a staff injury following an assault by a resident has been reported to WorkSafe; and the appointment of the facility manager and a resident absconding from the facility during the Covid-19 lock-down have been reported to HealthCERT.</p> <p>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 untoward events. A review of staff records demonstrated that staff receive education at orientation on the incident/accident reporting process.</p> <p>There is an implemented incident/accident reporting process and incident/accident reporting forms are available in the staff room. Interviews with staff and review of documentation evidenced that staff document adverse, unplanned or untoward events on an incident/accident form which is reviewed and signed off by the facility manager. These are entered onto the national incident reporting data base. Incident/accident reports selected for review evidenced that an appropriate assessment had been conducted, however not a form was not always completed and all required observations were not completed. There was evidence of a corresponding note in the resident's progress notes and notification of the resident's nominated next of kin where appropriate.</p> <p>Information gathered is shared at monthly meetings with incidents/accidents graphed and trends analysed</p>

		and discussed. Corrective actions arising from incidents/accidents were implemented for resident and staff incidents/accidents. Specific learnings and results from incidents/accidents inform quality improvement processes and are discussed at with staff at meetings.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Human resource management policies and procedures are in place. 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; and police vetting. There was evidence that relevant staff have additional role specific job descriptions. A performance process is in place and there was evidence that RNs employed longer than one year have a current performance appraisal. However not all other staff had a current performance appraisal.</p> <p>There is a system to ensure that annual practising certificates and practitioners' certificates are current including for example: RNs; GP; pharmacists; podiatrist; and physiotherapist.</p> <p>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 first aid; InterRAI; medication; manual handling and hand hygiene are reviewed and assessed annually. Interviews confirmed that new staff are supported until competent during their orientation into their new roles.</p> <p>A review of the management system confirmed that processes are in place to ensure that all staff complete their required training and competencies. Care staff working in the dementia unit have completed the required dementia unit standards within 18 months of appointment.</p> <p>The organisation has implemented the nationwide, role specific annual education and training modules. There is an electronic data base to record and track staff training/education, this is monitored by the regional manager. The CM is responsible for managing education and training at the facility. The electronic data base and education session attendance records evidenced that ongoing education is provided, and staff have undertaken a minimum of eight hours of relevant training.</p> <p>All RNs (seven), including the CM and one RN on leave, have completed InterRAI assessments training and competencies (refer to 1.2.3.8).</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe</p>	FA	<p>The organisation's allocation of staff and duty roster policy requires a base roster be set according to the needs of the client groups, individuals and numbers. Staff hours are required to be set to ensure that there are sufficient staff to provide safe care in a timely manner, taking into account dependency levels and time required to provide care. A roster is developed on a six-weekly basis, and reviewed to accommodate anticipated workloads. Rosters sighted reflected adequate staffing levels to meet resident acuity, bed</p>

<p>service from suitably qualified/skilled and/or experienced service providers.</p>		<p>occupancy and the requirements of the contract.</p> <p>A copy of each roster is made available to staff at least two weeks in advance. Staffing levels are reviewed to accommodate anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes residents' needs. There are sufficient RNs and care givers (CGs) available to safely maintain the rosters for the provision of care to accommodate increases in workloads and acuity of residents.</p> <p>The facility is made up of two main wings on one floor that include a mix of rest home and hospital level residents and a ground floor with a secure dementia unit. Each floor has a centrally located nurses' station. In addition to the CM who is on duty on the morning shifts from Monday to Friday, there is at least one RN on each morning, afternoon and night duty seven days per week. In addition, there are three CGs on each morning and afternoon shift and one on each night shift in the rest home/hospital wings. In the dementia unit there are two CGs on each morning and afternoon shift and one on each night shift. The one RN on duty for the facility on each shift, provides support to the dementia unit. In the advent that additional RN support was required after hours, the CM would be called.</p> <p>Both the facility manager and CM are on call after hours, seven days a week.</p> <p>There are 36 staff, including: the CM; administration; clinical staff; diversional therapist (DT); maintenance person and household staff. Household staff include cleaners, laundry staff and kitchen staff who provide services seven day a week.</p> <p>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 they are able to complete their scheduled tasks and resident cares over their shift.</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>An electronic medication management system is documented and implemented. The required three-monthly medication reviews by the GP were recorded electronically (refer to 1.3.3.3).</p> <p>The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. Weekly checks of controlled drugs are not consistently conducted. There are no standing orders used at the facility. There was evidence of RN transcribing of medicines.</p> <p>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.</p> <p>The clinical staff observed administering medication demonstrated knowledge and had a clear understanding of their roles and responsibilities related to each stage of medication management and complied with the</p>

		<p>medicine administration policies and procedures. Current medication competencies were evident in staff files.</p> <p>There was one resident self-administering medication during the on-site audit. A policy and process is documented and requires assessment of competency of the resident to self-administer medicines, monitor the administration and safe storage of medicines; however this is not occurring.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Moderate</p>	<p>The seasonal menus have been reviewed by a dietitian in March 2020. The food control plan's expiry date is January 2021.</p> <p>Food is stored appropriately in fridges and a freezer. Fridges and freezer temperatures and food temperatures are monitored and recorded in hard copy and on a computer; however, this does not always occur daily.</p> <p>Dry food supplies are stored in the pantry and rotation of stock occurs. All decanted dry stock containers were labelled and dated. The kitchen cleaning schedules are not always signed to ensure cleaning has been completed.</p> <p>A nutritional assessment is undertaken for each resident on admission by a RN to identify the residents' dietary requirements and preferences. The residents' dietary profiles were located in the residents' files and are also provided to kitchen staff. The residents' dietary profiles are located in the kitchen in a folder, however the residents' individualised dietary requirements are not always followed.</p> <p>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.</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>PA Moderate</p>	<p>Long-term care plans are completed by the RNs and based on assessed needs, desired outcomes and goals of the residents. The long-term care plans are not always completed within the required timeframe (refer to 1.3.3.3). For the rest home and the hospital residents, the care plan interventions are individualised and specific to the resident's needs and reviewed within required timeframes. The clinical records of residents' with dementia did not always record the required strategies to manage their challenging behaviours.</p> <p>The GP documentation and records reviewed were current. Interviews with residents and family member confirmed that care and treatment met residents' needs. Family communication is recorded in the residents' files. The nursing progress notes and observations are recorded and maintained (refer to 1.3.3.3).</p>
<p>Standard 1.3.7: Planned</p>	<p>FA</p>	<p>There are two activities programmes within the facility, which are planned and implemented by the DT. Activities for the residents are provided five days a week, Monday to Friday. The activities programmes were</p>

<p>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>displayed on the residents' noticeboards. The activities programme provides variety in the content and includes a range of activities which incorporate education, leisure, cultural, spiritual and community events. Regular van outings into the community are arranged.</p> <p>There are diversional therapy 24 hour wheel care plans that have the provision to record a resident's individual preferences hourly during day and night.</p> <p>The residents' activities assessments are completed within two weeks of the residents' admission to the facility, confirmed at the DT interview. The residents' activity needs are reviewed six-monthly, at the same time the long-term care plans are reviewed. There are 24 hour activities care plans for the residents' in the dementia unit, however these are not individualised (refer to 1.3.6.1).</p> <p>The residents and a family reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging and enjoying a variety of activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported at handover and in the progress notes (refer to 1.3.3.3). If any change is noted, it is reported to the RN or the CM.</p> <p>Long-term care plans are evaluated every six months in conjunction with the interRAI re-assessments or if there is a change in the resident's condition. Evaluations are documented by the RN. The evaluations include the degree of achievement towards meeting desired goals and outcomes.</p> <p>Residents and family interviewed confirmed involvement in the evaluation process. 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>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Moderate</p>	<p>A current building warrant of fitness is displayed in the entrance to the facility. Buildings and plant comply with relevant legislation.</p> <p>There is a process to complete service and maintenance checks of all areas and specified equipment such as hoists. However, evidence of checking and calibration of biomedical equipment was not sighted for all equipment. Interviews with staff and visual inspection confirmed there is adequate equipment available to support care.</p> <p>The maintenance person is responsible for general maintenance, including the gardens. Building maintenance is the responsibility of the building owner and some maintenance requires attention. Maintenance issues, including the reporting of these are discussed at staff meetings (refer to 1.2.3.8).</p> <p>All resident areas are accessible to residents including those with mobility aides. However, some areas</p>

		required attention to ensure resident safety. There is a centrally located courtyard in the dementia unit, with seating and shade and a sheltered walkway garden area for other residents that can be accessed freely by residents and their visitors.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	<p>The Ultimate Care Group surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. The infection control nurse is responsible for infection prevention and control in the facility and has a signed position description, which includes requirements of the role and responsibilities.</p> <p>Infection data is collated monthly and submitted to Ultimate Care 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.</p> <p>Interview with the CM confirmed there has been no outbreaks since the previous audit.</p>
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. On the day of the audit, no residents were requesting the use of enablers and one resident was using restraint.</p> <p>Review of clinical records of the resident using restraint was conducted and evidenced the required documentation relating to restraint use was evident. Regular training occurs and review of restraint and enabler use is completed and discussed at facility meetings (refer to 1.2.3.8).</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 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Low	<p>A complaints policy and process, in line with the Code is made available to residents and family. However resident interview and a review of complaints identified that not all complaints were managed in line with the Code. Although not all complaints had been responded to, residents and family stated that they felt comfortable in raising any issues or concerns with staff.</p>	<p>Not all complaints were managed in line with the Code, including:</p> <ul style="list-style-type: none"> i) Eight of thirteen documented complaints did not meet the timelines required by the Code. ii) Five of thirteen complaints had not had not be documented on a complaint form. ii) Two of the eight 	<p>Ensure that all complaints are managed in-line with the requirements of the Code.</p> <p>90 days</p>

			documented complaint forms had not been signed off.	
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	A complaints register is in place, with some but not all, hard copies of supporting information maintained in the complaints folder. However not all complaints during 2019 and up to June 2020 had been documented appropriately in the register.	<p>i) Seven of thirteen documented complaints reviewed had not been added to the complaints register.</p> <p>ii) Three of five complaints logged on the complaints register did not have supporting documentation available in the complaint file.</p>	<p>Ensure that:</p> <p>i) An up to date complaints register is maintained of all complaints.</p> <p>ii) Supporting documentation for each complaint is maintained on the complaints register.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	Corrective actions arising from quality improvement activities such as internal audits and accidents and incidents were fully implemented. Meeting minutes identify responsibilities, timeframes and evidence of signoff. However, this was not consistently evidenced in all general staff meeting minutes. Findings from internal audits informed quality improvements.	Staff meeting minutes did not consistently evidence that actions arising, responsibilities, timeframes and sign off had been documented.	<p>Ensure that corrective action points arising are fully documented for all staff meeting minutes.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward</p>	PA Low	Incident/accident reports selected for review evidenced that an appropriate assessment had been conducted for patients who sustained a fall. Initial assessments were completed, and family and general practitioner (GP) notified following a resident	Not all incidents/accidents were documented on incident forms	<p>Ensure that:</p> <p>All resident incidents/accidents are documented</p>

events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.		incident. However, incident forms were not consistently completed for all falls nor were a full suite of neurological observations completed for unwitnessed residents falls.	and not all residents who had an unwitnessed fall received neurological observations in accordance with best practice.	and reported on an incident form and all unwitnessed falls receive neurological observations in accordance with best practice. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Staff receive training and education as scheduled from an up to date national annual training programme. The organisation has an annual appraisal system, however, not all staff have a current appraisal. All RNs have completed and annual performance appraisal with the CM.	Five of six staff files reviewed did not have evidence of a current performance appraisal.	Ensure all staff undergo an annual performance appraisal. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	Six-monthly stocktakes are conducted and this was evidenced in the records reviewed. Medications are not consistently checked on weekly basis. The GP prescribes medications via the electronic medication management system. There was evidence of transcribing medicines on infection control records by the RNs.	i) Weekly medication checks are not always conducted. ii) Some medicines are transcribed by RNs.	i) Provide evidence of weekly medication checks. ii) Ensure medications are not transcribed. 90 days
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where	PA Moderate	There are policies and processes in place on self-administration of medicines by residents. Self-administration of inhalers on the days of the audit was observed. Review of resident's clinical records and interview with the CM confirmed resident's competency assessment to self-	Self-administration of medication competency assessments and three-monthly	Ensure self-administration of medicines is conducted according to policy

appropriate.		administer medicines was not conducted. Three-monthly reviews of capacity had not been conducted. Monitoring of the administration of the medicines was not always conducted by RNs. The medicines were observed not to be safely stored.	reviews are not always conducted. Monitoring of the administration of medicines and safe storage were not provided.	and guidelines. 90 days
Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.	PA Low	<p>Current nutritional assessments were in the residents' files reviewed and also in the kitchen. There is a white board in the kitchen for the purpose of quick visual reference for residents' preferences, diets and meal sizes, however the data on this whiteboard was out of date. There were a number of residents identified as requiring high protein diet that the relief cook was not aware of.</p> <p>The relief cook stated they are aware of how many soft diets are required, however, they are not aware of who the residents are that require these diets. Interview with the relief cook confirmed they were not aware of residents' likes and dislikes and preference of meal sizes.</p> <p>Dementia unit meals are plated by the cook in the kitchen and placed in a hot box for delivery to the unit. Dementia unit staff confirmed all meals are of the same size, even though some residents' meal sizes are recorded to be either small or large servings. The cook was aware of one resident requiring a large meal, however, there were number of residents requesting large portions in the rest home/hospital area.</p>	Residents' food preferences, special diets and serving sizes are recorded, however not always followed.	<p>Ensure kitchen staff follow the residents' individualised dietary assessments.</p> <p>90 days</p>
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with	PA Low	There are processes in place to monitor food and fridge and freezer temperatures by staff. Temperature monitoring in the kitchen is conducted by kitchen staff and either recorded on paper forms or into a computerized system. The relief facility manager stated not all staff know how to access or enter dietary and food related data electronically. There was evidence that	i) Food temperatures, fridge and freezer temperatures and kitchen cleaning records are not	i) Ensure all food related temperature monitoring and cleaning of kitchen is recorded

<p>current legislation, and guidelines.</p>		<p>monitoring of food and fridge/freezer temperatures did not occur daily. Kitchen cleaning records did not evidence consistent documentation.</p> <p>The facility has emergency water supply. The emergency water is stored in plastic containers and water was expired or not dated. The plastic containers were located throughout the facility in bathrooms, residents' rooms and kitchen.</p> <p>The facility does not have the recommended Wellington Regional Emergency Management Office water storage recommendation for Wellington (20 litres per person per day, for 7 days).</p>	<p>consistently recorded or accessible by all staff.</p> <p>ii) Emergency water supply is insufficient, not current and stored in residents' rooms, bathrooms and the kitchen.</p>	<p>consistently.</p> <p>ii) Ensure emergency water supply is sufficient for this facility, current and stored appropriately.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>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.</p>	<p>PA Moderate</p>	<p>Discussion with the administrator confirmed they have a process in place for signing of admission agreements. Review of residents' files evidenced not all residents had signed admission agreements.</p> <p>Review of the residents' medical progress notes evidenced the residents' initial medical assessments occurred within the required timeframes. For the residents examined by the GP less frequently than monthly, the required exception was not always noted and signed by the GP.</p> <p>The interRAI re-assessments are conducted six-monthly. Review of residents' clinical records of residents admitted to the facility in 2019 (prior to COVID-19 pandemic) evidenced the initial interRAI assessments were not always completed within the required timeframe.</p> <p>Long- term care plans were current in the clinical records reviewed. Review of resident clinical records, of residents admitted to the facility in 2019 (prior to COVID-19 pandemic), there was evidence the long-term care plans requiring to be completed within the residents' 21 days post admission to the facility were not always conducted within this timeframe.</p> <p>The progress notes entries occur on each shift. There was evidence all staff who contribute to progress note entries sign,</p>	<p>i) Residents' admission agreements do not always evidence sign off, as per aged residential care timeframes.</p> <p>ii) General practitioner exceptions are not consistently noted and signed by the GP for residents to be medically examined less frequently than monthly.</p> <p>iii) The interRAI assessments are not consistently completed within the 21 days of resident's admission</p>	<p>i) Ensure residents' admission agreements are signed within the required timeframe.</p> <p>ii) Ensure the GP exceptions are noted and signed by the GP for residents to be medically examined less frequently than monthly.</p> <p>iii) Ensure the interRAI assessments are completed within the 21 days of resident's admission to the</p>

		<p>and add their designation when completed. The time of recording of progress notes was not consistently recorded in the progress notes reviewed.</p> <p>The facility has a process and policy relating to wound management. Staff education has been provided relating to wound care. Review of the wound management folders and individual wound management assessment forms and treatment plans evidenced: the description of the wounds were incomplete and did not always specify the wound type; wound measurement was not always recorded; photo of the wound did not always occur; frequency of wound dressing changes were not always recorded; and the evaluation of management and treatment of the wounds did not consistently occur.</p>	<p>to the facility.</p> <p>iv) The long-term care plans are not consistently completed within 21 days of the residents' admission to the facility.</p> <p>v) The residents' progress notes do not always record times of entry.</p> <p>vi) Wound management processes do not adhere to service provision requirements.</p>	<p>facility.</p> <p>iv) Ensure the long-term care plans are completed within 21 days of the residents' admission to the facility.</p> <p>v) Ensure the residents' progress notes record times of entry.</p> <p>vi) Ensure wound management processes adhere to service provision requirements.</p> <p>180 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>Review of the clinical records in the dementia unit evidenced the long-term care plans record the residents' challenging behaviours and their management.</p> <p>The review of the long-term care plan and the 24 hour care plans evidenced there were specific challenging behaviours of residents that were not recorded or given the strategies how these should be managed. The 24 hour care plans recorded generic activities that were available during a specific time and the ability of the resident to participate in these. The 24 hour care plans reviewed did not record individualised residents' interests and specific strategies to guide staff in managing challenging behaviour.</p> <p>The challenging behaviour form evidenced the staff were recording the resident's challenging behaviour when it occurred,</p>	<p>Service provision in the dementia unit relating to challenging behaviour management does not always record strategies to manage challenging behaviours.</p>	<p>Ensure individualised interventions for residents with dementia who have challenging behaviours are recorded to guide staff in their management.</p> <p>90 days</p>

		<p>however; the time of the event was not always recorded; the strategies that were implemented and the outcomes were not always recorded. When challenging behaviour occurred they were not included in the long-term care plan.</p> <p>Discussion held with clinical staff confirmed that not all specific challenging behaviours of residents with dementia and the specific interventions were recorded to guide staff in management of challenging behaviours.</p>		
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA</p> <p>Moderate</p>	<p>The maintenance person undertakes repairs and maintenance of equipment. Equipment sighted appeared serviceable. However, the physical environment is not maintained to the required standard. Biometric calibrations are completed annually, and most equipment sighted demonstrated evidence of a current calibration check. All resident areas were easily accessible and warm; however, safety issues require attention, including snib-locks at a fire exit in the dementia unit. External areas were noted to be well maintained.</p>	<p>i) Cracked and lifting floor coverings and peeling paint were observed in resident communal bathrooms and toilets.</p> <p>ii) Communal toilets required cleaning.</p> <p>iii) Shower floors were observed to be left wet and slippery after patient showering.</p> <p>iv) A blood pressure monitor evidenced a last calibration check of 2018.</p> <p>v) Large four litre containers of shampoo and bodywash were available for communal use in</p>	<p>Ensure that:</p> <p>i) All surfaces maintained to a satisfactory standard.</p> <p>ii) Resident toilets are regularly cleaned when required after use.</p> <p>iii) Shower floors mopped after patient showering.</p> <p>iv) All equipment has evidence of a current calibration check.</p> <p>v) Residents have a personal supply of toiletries and that communal toiletries are not available for use.</p> <p>vi) Heating in areas accessed by</p>

			<p>showers room.</p> <p>vi) Unprotected oil fin heaters were used for heating in some resident rooms in the dementia unit.</p> <p>vii) A 'snib' lock was in place at the top of a fire exit door in the dementia unit.</p>	<p>residents is safe.</p> <p>vii) All fire exit doors can be exited safely and quickly in the advent of an emergency.</p> <p>90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.