

Melody Enterprises Limited - Ultimate Care Rhapsody

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:	Melody Enterprises Limited
Premises audited:	Ultimate Care Rhapsody
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 January 2021 End date: 13 January 2021
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:	59

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
Yellow	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
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Ultimate Care Rhapsody is an aged care facility certified to provide services for up to 72 residents requiring rest home or hospital levels of care. There were 59 residents at the facility on the first day of audit.

This unannounced surveillance audit was conducted against a subset of 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 residents' records and staff files; interviews with residents, family, management, staff, and a general practitioner.

There were six areas identified at the last certification audit requiring improvement. Five of the six areas relating to: staff training; information management system; care plans; emergency plan and emergency water supply have been closed at this surveillance audit. One of the six areas requiring improvement at the last certification audit relating to complaints remains open.

There were 11 new areas identified as requiring improvement at this surveillance audit relating to: communication; complaints register; corrective action plans; hazard register; accidents and incident management; human resource management; building warrant of fitness; residents' accommodation; timeframes of service delivery; evaluation of care plans; medication management systems and self-administration of medication.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---	--	---

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

Staff communicate with residents and family members following an accident/incident and this is recorded in residents' files. Interviews with residents, family and the general practitioner confirmed that staff are respectful of residents' needs.

Organisational management

<p>Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
--	--	---

The Ultimate Care Group is the governing body responsible for the services provided at this facility.

There are documented Ultimate Care Group quality and risk management systems. Quality and risk performance is monitored through the organisation's reporting systems. An internal audit programme is implemented.

The facility manager is responsible for the overall management of the facility. A clinical services manager supported by registered nurses, is responsible for the oversight of clinical service provision. The clinical services 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 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 are documented. Staff participate in an ongoing training programme.

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.
--	--	--

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

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

Short-term care plans are in place to manage short-term issues or problems as they arise. Interviews confirmed residents and their family are informed and involved in the care planning and evaluation of care. Handovers between shifts guide continuity of care and team work is encouraged.

The activity programme is managed by a diversional therapist. The programme provides residents with a variety of individual and group activities. Family involvement is encouraged.

There is an electronic medication management system in place. Medications are administered by registered nurses and senior care givers. Medicine management competencies reviewed for staff who administer medicines were current.

The food service meets the nutritional needs of the residents. The kitchen was clean and meets food safety standards. The food service has a food control plan that is current and displayed.

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.
--	--	--

There have been no alterations or additions to the facility's buildings since the last certification 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.

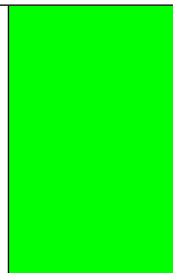


Standards applicable to this service fully attained.

The organisation implements policies and procedures that support the minimisation of restraint. There were no restraints or enablers in use at the time of audit. Staff interviews confirmed understanding of the restraint and enabler processes. When enablers are used, enabler use is voluntary. Restraint education is provided to staff at orientation and annually thereafter. A restraint register is maintained.

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.

Infection prevention and control surveillance is undertaken, analysed and trended. Results are reported to staff. Surveillance records showed evidence of follow-up of infection when required. Staff interviewed demonstrated current knowledge and practice of infection control principles.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	10	0	2	7	0	0
Criteria	0	32	0	4	8	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>	<p>PA Moderate</p>	<p>The organisation has a complaints policy and process to ensure that that complaints are managed in line with Rights 10 of the Code. The complaint form is made available to new residents and family on admission. The complaint forms are 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 (FM) is responsible for managing complaints. There is a complaints register; however, it was not up to date. Evidence relating to some, but not all, lodged complaints is held in the complaints folder. Interview with the FM and a review of the complaints indicated that not all complaints had been managed 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 management and they have been addressed.</p> <p>The audit team were advised that there have been no complaints made to external agencies since the last audit.</p> <p>The previous certification audit identified an area requiring improvement relating to documenting risk ratings associated with complaints, as these were not recorded or escalated to the appropriate senior clinical quality staff in the Ultimate Care Group (UCG) support office and this remains open.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>PA Low</p>	<p>There is an open disclosure policy to guide staff and management in open disclosure when an adverse event and/or harm during a resident's care has occurred.</p> <p>Review of: incident/accident forms; residents' records; and resident and family interviews demonstrated that family are informed if the resident has an incident/accident; a change in health or change in needs. Family contact is recorded in the resident's file.</p> <p>The prospective resident information brochure and the welcome pack for new residents do not include all required information for residents and family. The resident admission agreements are signed by the resident or enduring power of attorney (EPOA).</p> <p>The two-monthly residents' meetings inform residents of facility activities. The diversional therapist stated that copies of the meeting minutes are on facility notice boards.</p> <p>Resident and family interviews confirmed that the clinical services manager (CSM) and staff were approachable and available to discuss queries and issues. Interviews with residents and family identified that the CSM addressed concerns and queries promptly and proactively.</p> <p>Interview with the CSM 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 no residents who required the assistance of an interpreter.</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>The facility is part of the UCG with the executive management team providing support to the facility. The FM reports to a regional manager, with support from the wider UCG executive management team. Communication between the facility and the UCG executive management occurs regularly, as stated by the FM.</p> <p>There is an organisation wide quality and risk management document, and the business planning objectives of the facility are documented. Review of the facility's business plan for 2020 evidenced business objectives were recorded. The values and mission statement were not recorded in the facility's information pack provided to residents and their family on admission or displayed at the facility (refer to 1.1. 9.1).</p> <p>There is an electronic reporting of events and occupancy into the UCGs national system by the FM and the CSM, that facilitates review of progress against identified indicators by the executive management team. A range of performance indicators are monitored including but not limited to: admissions and discharges; staffing; compliments and complaints, infections; falls; weight loss and pressure injuries.</p> <p>The FM has been in this role for three months. They have qualifications in management. The FM is supported by a CSM who is a registered nurse (RN) and has been in this position for six months. The CSM has been employed at the facility as a RN and a team leader prior to the current position of the CSM. The CSM is supported by a team of RNs.</p>

		<p>The facility is certified to provide rest home care and hospital level care for up to 72 residents. There were 59 beds occupied at the time of the audit, this included: 47 residents who had been assessed as requiring rest home level care and 12 residents assessed as requiring hospital level care. Included in the total occupancy numbers was one resident who was under the age of 65 years, under the chronic long-term conditions agreement who were assessed as requiring rest home level care and one resident requiring respite care.</p> <p>The facility has contracts with the DHB for the provision of: rest home and hospital aged related residential levels of care; residential respite care; and long-term support- chronic health conditions agreement.</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 documented quality and risk management framework that is available to staff to guide service delivery. There is a UCG monthly report provided by the national office following facility's entry of clinical indicators. The national office implemented a new computerised system in December 2020, for facilities to enter their clinical indicators.</p> <p>Policies and procedures align with the Health and Disability Service Standards (HDSS) 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 UCGs internal network. New and revised policies are presented to staff and staff interviews and data confirmed that they are made aware of these.</p> <p>Quality improvement activities are discussed at facility meetings; however, not all meeting minutes evidenced corrective action plans when these were identified.</p> <p>There was evidence that the annual internal audit programme is implemented as scheduled. Quality improvement data sighted provided evidence that data is being collected and collated with the identification of trends and analysis of data. Corrective action plans following internal audits are developed, implemented, evaluated and signed off where required. There is communication with staff of any subsequent changes to procedures and practice through staff meetings.</p> <p>Annual satisfaction surveys for residents and family are completed and showed 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 prompt reporting of hazards and accidents/incidents. Staff interview confirmed that hazard reporting occurs. There was evidence that identified hazards are addressed and risks minimised, however the hazard register requires review.</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 Moderate</p>	<p>Management 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 the appointments of the FM and CSM have been reported to HealthCERT. The infection outbreak that occurred in January 2020 was reported to the appropriate authority.</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. Staff receive education on the incident/accident reporting process.</p> <p>There is a documented incident/accident reporting process. Interviews with staff and review of documentation evidenced that staff document adverse, unplanned or untoward events. These are entered onto the national incident reporting database. Incident/accident reports selected for review evidenced that an appropriate assessment had been conducted. However, not all required observations following un-witnessed audits had been 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>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>	<p>PA Moderate</p>	<p>Human resource management policies and procedures are documented. The skills and knowledge required for each position are documented in job descriptions.</p> <p>Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; a signed employment agreement; specific job description; and police vetting. There is a system to ensure that annual practising certificates (APCs) are current including for example: RNs; GP; pharmacists; podiatrist; and physiotherapist. Review confirmed all staff who require this, have current APCs.</p> <p>A performance process is in place, however not all staff had a current performance appraisal.</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; however, not all staff files evidenced staff orientations were completed.</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. The organisation has implemented the nationwide, role specific annual education and training modules. There is an electronic database to record and track staff training/education, that is monitored by the CSM. The CSM is responsible for managing education and training at the facility. 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. The previous area identified as requiring improvement relating to the annual mandatory staff training programme is now closed. There is recorded evidence</p>

		<p>that mandatory training has occurred for individual staff members. The education staff had attended was evidenced in staff files, training attendance records and the training register.</p> <p>There are six RNs, including the CSM. Three of the six RNs have completed interRAI assessments training and competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The organisation's allocation of staff and duty roster policy requires a base roster be set according to the needs of residents, taking into account dependency levels.</p> <p>Staff rosters are developed and reviewed to accommodate anticipated workloads, identified numbers of residents to ensure safe staffing levels within the facility are sufficient to meet the needs of residents' acuity and the minimum requirements of the DHB contract, stated by the FM and CSM.</p> <p>There are sufficient RNs and health care assistants (HCA) available to safely maintain the rosters for the provision of care to accommodate increases in workloads and acuity of residents.</p> <p>In addition to the CSM 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 seven HCAs on morning shifts; six HCAs on afternoon shifts and two HCAs on each night shift at the facility.</p> <p>Both the FM and CSM are on call after hours, seven days a week.</p> <p>Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy, and the requirements of the contract.</p> <p>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 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The previous certification audit identified an area requiring improvement relating to there not being a system in place to manage a systematic approach to the storage of residents' records, including ease of access and retrieval and this is now closed.</p> <p>An interview with the administrator, identified a new system has been implemented to manage archived patient information since the previous audit.</p> <p>Following a resident's discharge from the facility, their records are collated and placed into a large envelope, with the resident's details recorded on the envelope. The envelope is then stored in the archive room in a systematic way. All records are accessible by authorised personnel only and archived records are securely stored and easily retrievable at the facility.</p>

		Visual inspection of the archive room evidenced an organised, easy retrieved system of archived files.
<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>A current medication management policy identifies all aspects of medicine management in line with the medicines care guide for residential aged care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices in line with legislation, protocols and guidelines were observed. The required three-monthly reviews by the GP were recorded electronically. However, resident allergies and sensitivities were not consistently documented on the electronic medication chart.</p> <p>The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy.</p> <p>Review of the medication fridge evidenced that the service does not store or hold vaccines and interviews with the RN confirmed this. The medication refrigerators' and medication rooms' temperatures are monitored daily. However, no corrective actions are implemented when the drug room temperature is above 25 degrees.</p> <p>Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration. Weekly checks and six-monthly stocktakes of medications are conducted in line with policy and legislation.</p> <p>The staff observed administering medication demonstrated knowledge and at interview demonstrated clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures. The RNs oversee the use of all pro re nata (PRN) medicines and documentation made regarding effectiveness on the electronic medication record and in the progress notes was sighted. Current medication competencies were evident in staff files.</p> <p>There were nine residents in the facility self-administering medication during the on-site audit days. All had been approved to do so by the GP and the three-monthly competency checks were current; however, the facility did not provide safe storage for medications in the residents' rooms.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are</p>	<p>FA</p>	<p>All meals are prepared on site and served in the dining rooms or in the resident's room if requested. The seasonal menu has been reviewed by a dietitian, with the summer menu implemented at the time of audit. The food control plan is current.</p> <p>Food temperatures are monitored appropriately and recorded. The kitchen was observed to be clean and the cleaning schedules sighted.</p>

<p>met where this service is a component of service delivery.</p>		<p>A nutritional assessment is undertaken for each resident on admission by the 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. 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.</p> <p>Residents were observed to be given sufficient time to eat their meal and assistance was provided when necessary. Residents and family interviewed stated that they were satisfied with the meals provided.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit comply with current legislation and guidelines. The cook is responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately in fridges, 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. All dry stock containers are labelled and dated.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The residents' long-term care plans reviewed evidenced their recorded care plan interventions, based on the assessment of the resident, focused on their desired outcomes and the previous finding has been closed out. However, long-term care plans were not consistently developed for all residents within the timeframes specified in the aged related residential care agreement (refer to 1.3.3.3).</p> <p>Review of care plans evidence that short-term care plans are in place on the system for all acute problems/infections.</p> <p>Interviews with residents and family confirmed that care and treatment met residents' needs. Family communication is recorded in the residents' files. The nursing progress notes and observations are maintained as per UCG policy.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The GP documentation and records reviewed were current. The GP interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the resident's needs.</p> <p>There is evidence of wound care products available at the facility. The review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were recorded and measurements taken where this was required. Where wounds required additional specialist input, this was initiated.</p> <p>Staff interviews confirmed that they have access to the supplies and products they require to meet residents' needs. Monthly observations such as weight and blood pressure are completed and are up to date. Residents'</p>

		<p>family members interviewed expressed satisfaction with the care provided.</p> <p>Family communication is recorded in the residents' files. The nursing progress notes are recorded and maintained.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The residents' activities programme is implemented by two diversional therapists who work Monday to Friday 8:30am-5:00pm and 9:00am-3:30pm respectively.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six-monthly care plan review; however, evaluations do not always occur within the required timeframe (refer to 1.3.3.3).</p> <p>The activities programme was displayed. A range of activities are planned which incorporate education, leisure, cultural and community events. Church services are held monthly and chaplains visit weekly. Entertainers, happy hour and van outings occur weekly. The activities programme is discussed at the residents' meetings and residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the activities on offer.</p> <p>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>	PA Moderate	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. However, as Ultimate Care Rhapsody is now using an electronic system for resident records formal evaluations and evaluations when there are changes in the resident's condition cannot be completed until the system is fully functioning. Long-term care plan and evaluation documents are scanned into the gallery and there is no provision for updating these documents (refer 1.3.3.3).</p> <p>Short-term care plans are developed for acute problems when needed and record goals and the required interventions for the identified short-term problems. The short-term care plans reviewed were signed, dated and closed out when the short-term problem had resolved.</p> <p>Residents and family interviewed confirmed involvement in the evaluation process and any resulting changes. Contact with family was verified, this is documented in the individual resident files reviewed.</p>
<p>Standard 1.4.2: Facility Specifications</p>	PA Moderate	<p>The building warrant of fitness (BWOFF) expired on 14 January 2021. Management and staff interviews confirmed there have been no building alteration or additions to the facility.</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>There are 70 single rooms and two double rooms at the facility that are used to accommodate residents assessed as requiring care for specified DHB contracts. Both double rooms were occupied by one resident and one single room was occupied by a couple on audit days.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There were two areas identified as requiring improvement at the last certification audit relating to the emergency plan for the facility and emergency water supply. Following this surveillance audit they are now both closed.</p> <p>Interviews with staff and management, and review of the documented emergency plan evidenced this is facility specific and current.</p> <p>Ultimate Care Rhapsody has a tank of 8,000 litres of water that is located at the property. Interview with the maintenance person confirmed this water supply is available and used by the facility. Visual observation evidenced the tank is located on the property and there is sufficient water supply in an emergency.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection control nurse (ICN) is a RN. There is a signed position description, which includes requirements of the role and responsibilities. The ICN is supported by the CSM. The ICN is responsible for the infection control surveillance programme.</p> <p>Infection control surveillance occurs monthly with analysis of data and reporting at staff and quality meetings. The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infections.</p> <p>Interviews with staff reported they are made aware of infections through handover, progress notes, short-term care plans and verbal feedback from the CSM, RNs and the ICN.</p> <p>There has been one outbreak since the previous audit, a norovirus outbreak in February 2020. The outbreak was reported and managed well.</p> <p>Covid-19 information is available to all visitors to the facility. Ministry of Health information was available on site. Infection prevention control resources were available should a resident infection or outbreak occur. Staff have received training in Covid-19 preparedness and donning and doffing of personal protective equipment.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate</p>	<p>FA</p>	<p>Ultimate Care Rhapsody restraint minimisation and safe practice policies and procedures comply with legislative requirements.</p> <p>The CSM is standing in for the restraint coordinator who is on maternity leave. The CSM has had training in</p>

that the use of restraint is actively minimised.		restraint minimisation and safe practice. A signed position description was sighted. The restraint register is maintained. There were no residents using restraints or enablers at the time of the on-site audit. Interviews with staff confirmed enabler use is voluntary. Restraint minimisation and safe practice education is provided to all staff at orientation/induction to the service and ongoing education is provided to staff annually.
--	--	--

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>	<p>PA</p> <p>Moderate</p>	<p>A complaints form, in line with the Code is made available to residents and family.</p> <p>Review of the complaints identified, that not all complaints were managed in line with the Code.</p> <p>The complaints are to be risk rated and when required, escalated to the appropriate national senior clinical quality staff member. There was evidence the complaints reviewed did not record a risk rating, as identified at the previous audit, and this finding remains open.</p> <p>The review of the documented complaints evidenced: the process of informing the complainant of the facility's complaints procedure, including the availability of an independent advocate and the Health and Disability Commissioner were not always conducted; the investigations were not consistently recorded and the</p>	<p>Not all complaints were managed in line with the requirements of the Code.</p>	<p>Ensure that all complaints are managed in line with the requirements of the Code.</p> <p>90 days</p>

		complaints were not always signed off as resolved.		
<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 hard copies of supporting information maintained in the complaints folder. However, not all complaints in 2020 had been documented in the complaints register.	The complaints register was not up to date.	<p>Ensure that an up to date complaints register is maintained of all complaints.</p> <p>180 days</p>
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	<p>Interview with the administrator confirmed a booklet is provided to residents and family members at an initial enquiry, regarding the services at the facility. This booklet provides information on the facility's services; however, it requires review.</p> <p>On a new resident's admission to the facility, the resident and their family are provided with a folder containing: the resident admission agreement; resident's activities social profile form; the complaint form and Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) information. Facility information containing information relating to the facility including but not limited to: food service; activities; cultural services; facility philosophy, mission statement, values and belief; staffing; fire safety; that is provided to residents and family on enquiry is not provided to new residents and family on admission to the facility.</p>	Not all required information is provided to new residents and their family on admission to the facility.	<p>Ensure all new residents and their family are provided with detailed information about the services provided at the facility.</p> <p>180 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</p>	PA Low	Corrective action plans are completed for quality activities and communicated to all concerned. However, corrective actions arising from meeting minutes did not always identify person responsible, timeframes of corrective action	Meeting minutes did not consistently evidence that actions arising,	Ensure that corrective action plans arising are fully

developed and implemented.		and evidence of sign off.	responsibilities, timeframes and sign off had been documented and implemented.	documented and implemented for all meetings conducted at the facility. 180 days
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	PA Low	<p>There is a hazard policy and new hazards are identified and actions taken as appropriate. Staff and management interviews confirmed their awareness and responsibility to report hazards.</p> <p>The hazard register was not current. The facility hazard register was last reviewed in March 2019.</p>	The facility's hazard register is not current.	<p>Ensure the hazard register is current.</p> <p>180 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Moderate	<p>Incident/accident reports selected for review evidenced that an appropriate assessment had been conducted for patients who sustained a fall. However, the completed incident forms evidenced that a full suite of neurological observations were not always completed for un-witnessed residents' falls. Family and the general practitioner (GP) were notified following a resident incident.</p> <p>Staff report accidents and incidents on a hard copy form and this is entered onto a computerised incident</p>	Residents' unwitnessed falls did not have evidence of appropriate neurological observations being completed.	<p>Ensure that full neurological observations are completed for all residents who experience unwitnessed</p>

		<p>management system. Review of adverse events forms for unwitnessed falls evidenced the use of two neurological observation forms. One form records that the neurological observations are to be taken half hourly for four hours and a second form records that the neurological observations are to be taken half hourly for two hours. Interview with the CSM confirmed this was the UCG policy, however with the introduction of a new computerised system in December 2020 a new process has commenced. Staff are to record the incident directly onto the computer and the system instructs the staff to record neurological observations for 72 hours post unwitnessed falls.</p> <p>The review of five hard copy adverse events forms relating to un-witnessed falls evidenced neurological observation were not followed for all five events. Review of a resident who had a fall on first day of the audit and had this event recorded in the new computer system also evidenced the new process was not followed for neurological observation post their unwitnessed fall.</p>		<p>falls.</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Moderate</p>	<p>The organisation has processes in place for human resource management.</p> <p>Review of management and staff files evidenced orientation had not been completed for four of the nine staff and management files reviewed. The FM and the CSM did not have evidence they had commenced or completed their orientation. Two staff have commenced their orientation; however, their orientation records were not signed off as completed six months and four months post their date of employment.</p> <p>Five of nine staff files evidenced staff performance reviews have not been conducted. Staff interviews confirmed not all staff had their performance reviews completed annually.</p>	<p>Human resource processes relating to orientation and performance reviews are not always conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>Ensure human resource processes relating to orientation and performance reviews are conducted in accordance with good employment practice and meet the requirements</p>

				of legislation. 90 days
<p>Criterion 1.3.12.1</p> <p>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.</p>	<p>PA Moderate</p>	<p>Medication refrigerator and room temperatures were being recorded daily in the rest home and hospital. In the 2 days prior to the audit the hospital drug room temperatures had been above 25 degrees celsius. In the rest home for 12 days prior to the audit the medication room temperatures had been above 30 degrees, on the second day of the audit the temperature recorded was 37 degrees. No corrective action had been taken to address this issue.</p> <p>Ten medication charts were reviewed. In four out of ten medication charts reviewed resident medication allergies and sensitivities had not been documented.</p>	<p>i) Corrective actions had not been developed or implemented to address drug room temperatures of above 25 degrees celsius.</p> <p>ii) Information relating to residents allergies and sensitivities was inconsistently documented.</p>	<p>i) Ensure corrective action is taken to ensure drug room temperatures are always within recommended range.</p> <p>ii) Ensure all information relating to residents' allergies and sensitives is clearly documented.</p> <p>30 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Moderate</p>	<p>There were nine residents self-administering medication. General practitioner approval and three-monthly competency checks for all nine residents were sighted. However, no safe storage for the medications being self-administered was provided in the residents' rooms.</p>	<p>Safe storage is not provided for residents self-administering medication.</p>	<p>Ensure that safe storage for residents self-administering medication is provided.</p> <p>30 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>InterRAI assessments are completed for new residents within three weeks of admission and six monthly thereafter. Documents scanned into the electronic system were not able to be altered or updated therefore evaluations and changes to the care plan had not been carried out. Initially five files were reviewed on the electronic system; none had a long-term care plan available in the care planning section. The hard copy files were requested, made available and the five long-term care plans reviewed. However, these were unavailable for care staff use in the rest home or hospital as they were locked in the administration area.</p> <p>The CSM stated that scanned copies of long-term care plans were available in the electronic system's gallery. Sampling was extended and a further 10 files were reviewed specifically to ascertain whether a current long-term care plan was available for staff to access, had been evaluated within the correct timeframes and whether changes were able to be made to the plans.</p> <p>Of the further 10 resident's records reviewed:</p> <p>Five had long-term care plans scanned in the gallery; however, the six-monthly evaluation was overdue for three out of these five resident records.</p> <p>Two residents did not have their long-term care plan scanned into the gallery and the hardcopy was not accessible to care staff.</p> <p>Three remaining records were for residents who were more recently admitted. However, a long-term care plan had not been developed within the required three-week timeframe.</p>	<p>i) Long-term care plans are not consistently evaluated within the required timeframes or when changes occur.</p> <p>ii) Long-term care plans are not consistently available to staff caring for residents.</p> <p>iii) Long-term care plans have not been developed for all residents within the required timeframes.</p>	<p>i) Ensure that long-term care plan evaluations are completed with the required timeframes or when changes occur.</p> <p>ii) Ensure that resident information including long-term care plans are accessible for all RNs and HCAs.</p> <p>iii) Ensure all residents have a long-term care plan developed within the required timeframes</p> <p>30 days</p>
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected,</p>	<p>PA Moderate</p>	<p>Short-term care plans are reviewed, signed and closed off when the acute problems are resolved.</p>	<p>Evaluation of the long-term care plans is</p>	<p>Ensure evaluation of long-term care</p>

<p>the service responds by initiating changes to the service delivery plan.</p>		<p>However, of the 11 resident long-term care plans reviewed which required evaluation; 5 did not have an evaluation documented within the required timeframe.</p> <p>Resident records were unavailable for updating as the hard copy was scanned onto the gallery and then archived. Documents were not electronically available for making changes.</p>	<p>not being carried out in accordance with HDSS and the DHB contract.</p>	<p>plans is carried as per HDSS and DHB contract.</p> <p>30 days</p>
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Moderate</p>	<p>The facility's BWOFF expired on 14 January 2021.</p> <p>Interview with the FM confirmed a process to review the BWOFF had commenced, however there was no evidence of data/records to be able to confirm this had occurred.</p> <p>The facility has 72 bedrooms, which includes 2 double rooms. Visual inspection of the double rooms evidence rooms that could accommodate two beds and have two call bells. Both double rooms were used for single occupancy at the time of this audit.</p> <p>Interview with a family member confirmed a married couple were residing in a single room. Visual inspection of the room confirmed this is a single room. The couple do not have additional room that they can use.</p>	<p>i) Building warrant of fitness expired on 14/01/2021.</p> <p>ii) There are two residents residing in a single room.</p>	<p>i) Ensure the BWOFF is current.</p> <p>ii) Ensure single rooms are used for single occupancy.</p> <p>7 days</p>

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.