

The Ultimate Care Group Limited - Ultimate Care Palliser House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: The Ultimate Care Group Limited

Premises audited: Ultimate Care Palliser House

Services audited: Hospital services - Medical services; Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 21 January 2021 End date: 21 January 2021

Proposed changes to current services (if any): Reduction in the dementia beds from 20 to 10 and increase in the dual-purpose beds (rest home/hospital) from 12 to 22, maintaining the same number of beds in the facility (32 total).

The reconfiguration involves moving the door between the dementia unit and the dual-purpose unit, pertaining 10 dementia rooms to become dual-purpose.

Total beds occupied across all premises included in the audit on the first day of the audit: 14

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.

General overview of the audit

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

This partial provisional audit was conducted against a subset of the Health and Disability Services Standards and the services' contract with the district health board. The audit was undertaken to assess the facility preparedness to provide services under proposed reconfiguration changes.

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

Areas requiring improvement relate to: performance appraisals; service provision; planned activities; medication management; hazard register; residents' fridges monitoring; firefighting equipment; communal showers/toilets privacy locks; and the laundry service. There is one external access to secure prior to occupancy.

Consumer rights

Not audited

Organisational management

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

Systems are in place for the monitoring of delivered services, including reporting by the nurse manager to a regional manager. There is an existing plan for the day-to-day management of the facility, which remains unchanged following the reconfiguration of services.

The nurse manager is a registered nurse with aged care and management experience. The nurse manager is also responsible for the oversight of the clinical services.

Policies and procedures on human resource management align with good employment practice. A mandatory education programme is provided for staff.

The planning of staffing levels and skill mixes follows a documented rationale based on best practice to support safe service delivery. Current rosters meet the requirements of the reconfigured care units.

Continuum of service delivery

Registered nurses assess residents on admission. The interRAI assessment is used to identify residents' needs and are completed within the required timeframes.

Care plans are developed when required using an electronic system, are individualised and include an integrated range of clinical information. The care planning process involves residents and their relatives, who stated they are notified of any changes in the resident health status.

Handovers between shifts guide continuity of care and teamwork is encouraged.

The activity programme is managed by an activities' coordinator. The documented programme includes a variety of individual or group activities and maintenance of links with the community.

An electronic medication management system is in place. Medications are administered by registered nurses who have completed current medication competencies. The proposed reconfiguration does not impact on the medication management and administration system.

The food service meets the nutritional needs of the residents. All meals are prepared on-site. The service has a current food control certificate. Kitchen staff hold food safety qualifications. The food service operations continue to meet requirements under the planned reconfiguration.

Safe and appropriate environment

A building systems status report is displayed and current.

A reactive and preventative maintenance programme is documented.

All residents' bedrooms, including those which have been re-purposed under the reconfiguration, allow space for the use and manoeuvring of mobility aids and the provision of care assistance. There is enough showers and toilets accessible to residents in both proposed units. Lounges, dining areas and sitting alcoves are available for residents and their visitors in the planned areas. External areas and gardens are accessible for all residents.

Policies and processes are in place for waste management, cleaning and laundry. The reconfiguration does not impact on these services. Cleaning of the facility is conducted by care giving staff and monitored.

Implemented security and emergency systems remain suitable after the reconfiguration. Regular fire drills are completed.

The facility has natural light, ventilation and heating systems.

Restraint minimisation and safe practice

Not audited.

Infection prevention and control

The infection control programme which is appropriate for the size and complexity of the service, does not need changing under the planned reconfiguration. The infection control nurse is a registered nurse. Infection data is collated, analysed, trended and benchmarked. Monthly surveillance data is reported to staff and to the Ultimate Care Group national office. There has been one outbreak since the previous audit.

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	9	0	4	4	0	0
Criteria	0	29	0	4	4	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 1.2.1: 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>Ultimate Care Palliser House (Palliser House) is part of the Ultimate Care Group (UCG). The organisation communicates its mission, values and goals to residents, family and staff through posters sighted at the entrance to the facility and information booklets.</p> <p>Ultimate Care Group executive management team provides support to the facility with the regional manager providing support during this on-site audit. The nurse manager (NM) informs the executive management team of monthly progress against identified indicators.</p> <p>Interviews with the regional manager and the NM advised that the proposed configuration changes respond to a shift in demand for current services.</p> <p>The NM who is responsible for the overall management of the service, including clinical aspects, has been in the role since June 2020. The NM is a registered nurse (RN) with managerial experience in aged-related residential care (ARRC) facilities. The required authorities have been informed of the appointment of the NM.</p> <p>The facility can provide care for up to 32 residents, with 14 beds occupied at the time of audit. This included: five residents requiring rest home level care; five</p>

		<p>residents requiring hospital level care; and four residents receiving dementia care.</p> <p>The facility holds contracts with the district health board (DHB) for ARRC; short-term residential care; and long-term support – chronic health conditions (LTS-CHC).</p> <p>Planned reconfiguration of services includes a reduction in dementia beds by 10 and an increase in dual-purpose beds by 10, maintaining the same total number of beds in the facility at 32 (10 dementia beds from 20, and 22 dual-purpose beds from 12).</p> <p>The relocation of security doors between the secure dementia unit and the dual-purpose area support the reconfiguration (refer to 1.4.2.1). No additional organisational or structural changes are required or anticipated.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the absence of the NM, a senior RN is delegated to perform this role with the support of the regional manager. To cover an extended leave of the NM, the regional manager interviewed confirmed they would appoint a UCG relieving NM for the organisational management of the facility, and a senior RN to provide oversight of the clinical cares.</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>	PA Low	<p>Written policies and procedures in relation to human resource management are available that meet the requirements of legislation.</p> <p>Current copies of annual practising certificates were identified for all staff and contractors that require them to practice.</p> <p>The selection and approval of new staff is the responsibility of the NM. The skills and knowledge required for each position are documented in job descriptions, which outline accountability, responsibilities, and authority. These were evidenced in the staff files reviewed along with: employment agreements; reference checks; police vetting and current first aid certificates.</p> <p>The organisation has a documented mandatory annual education schedule and training modules specific to each role. The mandatory continuing education includes, but is not limited to: infection control; restraint/enabler use; and moving and handling.</p> <p>Staff interviewed, including RNs, confirmed that they undertake relevant</p>

		<p>education each year, and that an appraisal schedule is in place.</p> <p>However, not all staff received a performance review as per schedule.</p> <p>Staff education records evidenced completion of ongoing training and competencies. The previous corrective actions, relating to a centralised system to record and track ongoing training and competencies and first aid certificates are now closed.</p> <p>Two RNs were identified as interRAI competent. Care giver staff have either completed or commenced a New Zealand Qualification Authority education programme, including on dementia care to meet the requirements of the provider's agreement with the DHB.</p> <p>Interviews with care givers confirmed new employees are paired with senior peers until they demonstrate competency of tasks, including personal cares for residents.</p> <p>No changes to current employed staff are required for the planned reconfiguration.</p> <p>Staff interviewed confirmed knowledge and understanding of the reconfiguration of services that was explained to them.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Ultimate Care Group has a documented and nationally implemented process for determining staffing levels and skill mixes that support safe service delivery, 24 hours a day, 7 days a week. The national team oversees the roster with the NM adjusting staffing levels locally to meet the changing needs of residents.</p> <p>The facility has a separate roster for the dual-purpose (rest home/hospital) unit, and the dementia unit. A RN is rostered on 24 hours a day, 7 days a week to support both units. There are enough staff in the two care units to cover staffing requirements under the provider contract with the DHB, and the reconfiguration proposal.</p> <p>Observations and review of roster cycles confirmed adequate staff cover has been provided, with staff replaced in any planned or unplanned absence.</p> <p>Care givers reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>The NM or a RN are on call after-hours and during weekends to support the</p>

		facility with emergency matters.
<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 legislation and guidelines.</p> <p>A 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. Resident allergies and sensitivities were 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. A system is in place for returning expired or unwanted medication to the contracted pharmacy.</p> <p>However, medicines with a limited shelf life after opening did not always show records of their expiry date once opened. The area identified as requiring improvement from the previous audit still need addressing.</p> <p>There are no standing orders used at the facility.</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 refrigerator temperatures are monitored daily.</p> <p>However, the temperature of the medication room is not monitored.</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. The area identified as requiring improvement from the previous audit is now closed.</p> <p>Registered nurses oversee the use of all pro re nata (PRN) medicines and documentation of their effectiveness was sighted in the electronic medication records.</p> <p>Current medication competencies for staff administering medicines were evident in staff files reviewed.</p> <p>There were no residents self-administering medication during the on-site audit.</p>

		<p>The proposed reconfiguration has no impact on the current medication management system. There is no change to the location of the medication room or the number of residents at the facility.</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>FA</p>	<p>All meals are prepared on site and served in communal dining rooms or in the resident individual rooms if requested. Dining spaces availability is unchanged after the reconfiguration of rooms.</p> <p>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. Food management training and certificates for cooks and kitchen staff were sighted.</p> <p>Food temperatures are monitored and recorded as required. The kitchen staff have relevant food hygiene and infection control training. The kitchen was observed to be clean and the cleaning schedules were sighted.</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 following six-monthly reviews or when the resident dietary needs change. The chef interviewed confirmed awareness of the dietary needs, likes and dislikes of the residents. These are accommodated in daily meal planning.</p> <p>On observation, residents were given time to eat their meal and assistance 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 a cool store. Temperatures of fridges and the freezer are monitored and recorded daily (refer to 1.4.2.1). Dry food supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated.</p> <p>Proposed changes to care services have no incidence on the food delivery or the food service requirements provided.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Moderate</p>	<p>The residents' activities programme is overseen by a diversional therapist from another UCG facility. The previous area of improvement identified at the last audit relating to this is now closed.</p> <p>A documented activities programme was identified on display in the facility. The programme supports variety in the content and includes a range of activities which incorporate: education; leisure; cultural; spiritual and community events. The activities programme takes place in the dementia unit to enable all residents to participate and continues to do so after the new configuration.</p> <p>The activities planning covers a seven days period. However, there was no evidence that the planning was implemented during the days when the activities coordinator was off duty.</p> <p>The activities coordinator completes sighted residents' activities assessments within three weeks of residents' admission, in conjunction with the residents/families and the admitting RN.</p> <p>However, long-term care plans do not contain interventions to manage challenging behaviours, or individual activities over a 24 hour period for the residents who live in the dementia unit. .</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>PA Low</p>	<p>There are policies and procedures in place for the management of waste and hazardous substances. Appropriate signage is displayed where necessary.</p> <p>An external company is contracted to supply and manage all chemicals and cleaning products, and provides relevant training for staff. Safety data sheets were available where chemicals are stored, and staff interviewed knew how to respond to any chemical spill/event, should they occur.</p> <p>There is provision and availability of protective clothing and equipment, with staff observed using them when required.</p> <p>However, the hazard register is not up-to-date.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are</p>	<p>PA Moderate</p>	<p>A building systems status report has been issued in lieu of a building warrant of fitness. The building warrant of fitness was unable to be issued during the Covid-19 level restrictions. The certificate is valid for 12 months and expires June 2021.</p>

<p>fit for their purpose.</p>		<p>No structural building alterations are required with the reconfiguration of services. A new internal security door and key pad have been placed where the reduced dementia unit starts. There is a plan to leave the existing security door open and key pad removed allowing additional space for the extension of the dual-purpose beds.</p> <p>A reactive and preventative maintenance system is documented to ensure the residents' physical environment and facilities remain fit for purpose.</p> <p>Temperatures of hot water from sanitary fixtures accessed by residents are monitored monthly. When there have been hot water temperatures above the recommended safe level, action is taken and rechecking of the temperature occurs to ensure maintenance within the required range.</p> <p>The temperatures of refrigerators in residents' rooms were not monitored.</p> <p>The testing and tagging of electrical equipment and calibration of bio-medical equipment is current as confirmed in documentation, interviewed with the NM and regional manager, and observations of the environment. The previous area for improvement related to this is now closed. However, improvement is still required for the firefighting equipment service checks.</p> <p>Both care units have separate nurses' stations that allow visibility of clinical staff to residents.</p> <p>The external areas are maintained and observed to be appropriate for the resident groups and settings. The gardens maintenance is contracted out. Residents, staff and visitors interviewed described the gardens as well kept and a source of visual enjoyment.</p> <p>The NM interviewed demonstrated a plan to install a new gated system to support ongoing access to a secured outdoor area by the dementia residents after the reconfiguration.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal</p>	<p>PA Low</p>	<p>Bedrooms throughout the facility have a toilet and a hand basin or a full ensuite.</p> <p>On inspection, there is adequate number of toilets and bathrooms of an appropriate design for all residents' service needs. Interviews with residents confirmed they are satisfied with their accommodation and use of communal bathroom facilities, and they believed the planned reconfiguration does not</p>

<p>hygiene requirements.</p>		<p>change this.</p> <p>Separate toilets are available for staff and visitors. The floors and wall surfaces sighted are constructed from materials that can be easily cleaned.</p> <p>Communal toilets and showers have a system that indicates if they are vacant or occupied, however, they do not have privacy locks.</p> <p>Approved handrails are provided along with other equipment/accessories that are required to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Residents' bedrooms visited during the tour of the facility are personalised to varying degrees. The bedrooms are single occupancy rooms. All bedrooms across all units are large enough to allow staff and equipment, such as hoists, to move around and provide personal space for residents.</p> <p>Management interviews and observations verified that no alterations are required to convert the 10 dementia rooms into dual-purpose rooms for the planned reconfiguration.</p> <p>Dedicated spaces were identified for the storage of mobility aids and wheelchairs.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Observed communal areas are available for residents to engage in group and individual activities in both units and remain suitable for the new configuration of services. In the reconfiguration plan, one dining/lounge area in the dementia unit, and two dining areas and one lounge area in the rest home/hospital unit remain accessible by residents and staff.</p> <p>Residents and family interviewed confirmed they can access areas for privacy, if required. Residents discussed alternative areas available to them if communal activities are taking place in the lounge areas, and they do not wish to participate.</p> <p>Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the</p>	<p>PA Low</p>	<p>Cleaning and laundry policies and procedures are available. The roles of cleaning and laundry are performed by care givers. Daily tasks sheets ensure these are completed.</p>

<p>setting in which the service is being provided.</p>		<p>Laundry is undertaken on site and on request, in dedicated laundry areas. Two separate areas, clean and dirty have been allocated to manage the laundry process.</p> <p>The previous area for improvement that relates to the delineation of laundry areas is now closed.</p> <p>However, improvement is still required regarding the laundry transportation.</p> <p>Care giver interviewed described the cleaning process and the use of chemicals for cleaning purposes. There are secure storage areas for cleaning equipment and chemicals, and relevant staff have access to these as required.</p> <p>Sluice rooms are available in both care units for the disposal of soiled water/waste.</p> <p>The NM and regional manager reported that the effectiveness of cleaning and laundry services is audited via the internal audit programme.</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>Documented systems are in place for essential, emergency and security services. The fire evacuation scheme for the facility has been approved by the New Zealand Fire Services. The reviewed trial fire evacuations are conducted six-monthly, with the last evacuation conducted in October 2020.</p> <p>The reconfiguration of services does not alter the fire plan, with the fire cell doors and exits remaining in the same place.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, and gas barbeques were sighted and meet requirements for the size of the facility. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Residents and family interviewed reported staff respond promptly to call bells.</p> <p>Appropriate security systems are in place. Doors and windows are locked at a predetermined time.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light,</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated. Rooms have natural light and open to external windows. Heating is provided by heat pumps and wall heaters. All areas of the facility were observed to be maintained at an</p>

<p>safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>adequate temperature and ventilated during audit. Residents and family explained that the facilities always provide a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Palliser House provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an infection prevention and control programme. A RN is the infection control nurse (ICN) and has access to external advice from the DHB ICN specialist. A documented job description for the ICN, including role and responsibilities, is in place.</p> <p>The infection control programme is appropriate for the size and complexity of the service; it is reviewed annually. Staff are made aware of new infections through daily handovers on each shift, progress notes and clinical records. There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff, residents, and visitors to use.</p> <p>Interview with the ICN confirmed there has been one outbreak in September 2020 (norovirus). Documentation reviewed confirmed that this had been managed and reported as required.</p> <p>Covid-19 information was observed to be available to all visitors in the facility, and included Ministry of Health information. Infection prevention and control resources are available, should a resident infection or outbreak occur.</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 1.2.7.2</p> <p>Professional qualifications are validated, including evidence of registration and scope of practice for service providers.</p>	PA Low	<p>There are policies and procedures in place for human resource management, that include a formal process for staff performance appraisals.</p> <p>However, review of sampled staff files evidenced that three of six staff did not have a documented performance appraisal in the required timeframe. Interview with the NM confirmed performance appraisals had not been completed in due course.</p>	Staff performance appraisals are inconsistently completed.	<p>Ensure all staff performance appraisals are completed in a timely manner.</p> <p>180 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage,</p>	PA Moderate	<p>i) Eyedrops are stored correctly either in the medication cupboard or the medication refrigerator. However, opened eye drops vials did not consistently have a documented use-</p>	<p>i) The use-by-date of medications with a reduced shelf live after opening is not always recorded.</p>	<p>i) Ensure the use-by-date of medications with a reduced shelf live after opening is recorded.</p> <p>ii) Ensure the drug room</p>

disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		by-date. ii) The medication fridge temperature is monitored and recorded daily. However, there is no documented evidence that the drug room temperature is monitored. Interview with the NM confirmed this was not done.	ii) The medication room temperature is not monitored.	temperature is monitored and documented. 30 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	Interview with the GP confirmed that they were notified of changes of residents' health conditions in a timely manner, and that their instructions were implemented by the clinical staff. However, a review of sampled residents' files evidenced that three of five residents did not have a GP admission assessment within the timeframe required by the DHB contract. One resident was seen by the GP 15 days after admission; another was seen 9 days after admission. The third resident was unable to be assessed within the required timeframe due to Covid-19 lockdown.	Not all residents had an initial GP assessment within the required timeframe following admission.	Ensure that all residents are assessed by a GP within the required timeframe following admission. 90 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Moderate	i) An activity programme is developed weekly. Staff interviewed advised that the activities coordinator leads the activities Tuesday to Thursday, 10:00am–3:30pm, while the care staff is responsible for the execution of the activities programme Friday to Monday. However, there was no documented evidence that activities occurred on the	i) Activities are not implemented on the four days per week that the activity coordinator is not at the facility. ii) Care plans for dementia care residents do not describe interventions, strategies	i) Ensure that planned activities are implemented and documented on the days that the activity coordinator is not at the facility. ii) Ensure long term care plans of the residents living in the dementia unit

		<p>days when the activities coordinator was not at the facility. Interview with a family member who visits the facility daily indicated that activities were not implemented on those days. Staff interviewed explained that the activities did not occur due to their workloads.</p> <p>ii) Information on residents' interests, family and previous occupations is gathered during the admission interview with the resident and their family and documented. The residents' activity needs are reviewed six-monthly at the same time than the care plans are evaluated, and they are part of the formal six-monthly multidisciplinary review process.</p> <p>However, in four out of four files reviewed of residents living in the dementia unit, the long-term care plan did not contain interventions, strategies or activities: to manage challenging behaviours; to support the residents' diversional, motivational and recreational needs over a 24 hour period.</p>	<p>or activities to manage challenging behaviours or to provide diversion over a 24 hour period.</p>	<p>include strategies, interventions and activities for managing challenging behaviours, as well as a 24 hour period activities plan.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.1.1</p> <p>Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.</p>	<p>PA Low</p>	<p>Palliser House has a hazard register that outlines hazards (including chemicals) to the facility, residents, and staff. On review of the register, it was noted this had not been updated since September 2019.</p>	<p>The hazard register was not current.</p>	<p>Ensure the hazard register is updated at least annually.</p> <p>90 days</p>

<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Moderate</p>	<p>i) The documented maintenance programme requires all firefighting equipment to be regularly checked. Reviewed documentation verified that an external provider is contracted to service check the fire equipment. On inspection, fire equipment did not always evidence a current check.</p> <p>ii) Residents' rooms in the rest home and hospital wing provide a space for a personal refrigerator. However, there was no documented evidence that the residents' fridge temperatures were monitored.</p> <p>iii) On inspection, there are two separate outdoor areas arrangements for the residents in the dementia unit and the dual-purpose unit. Dementia care residents were observed to have independent access to an external area suitable for walks and secure to promote their safety.</p> <p>After the reconfiguration however, one access leading to this outdoor area is connected to the rest home/hospital part of the building. There is a current plan explained by management to install a security system to make this access secured.</p>	<p>i) Not all firefighting equipment demonstrated evidence of a current check.</p> <p>ii) Temperatures of the refrigerators located in residents' rooms are not monitored.</p> <p>iii) Plan to secure the outdoor area in the dementia unit needs to be implemented.</p>	<p>i) Ensure all firefighting equipment demonstrates evidence of a current check.</p> <p>ii) Ensure temperatures of the refrigerators located in residents' rooms are monitored.</p> <p>iii) Ensure plan to secure outdoor area in the dementia unit is implemented.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in</p>	<p>PA Low</p>	<p>The residents, family and staff interviewed confirmed that the facility has enough toilet and shower areas close to the bedrooms. The reconfiguration of the units will allow</p>	<p>Privacy locks are not always available on communal showers' and toilets' doors.</p>	<p>Provide privacy locks on all communal showers' and toilet doors.</p>

<p>close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.</p>		<p>three toilets, two showers and one ensuite to be shared by ten residents in the dementia unit. The rest home/hospital unit will have 8 ensuites, 4 toilets in bedrooms, 2 communal showers, and 4 communal toilets to be shared between 22 residents.</p> <p>However, on observation all communal toilets/showers did not have privacy locks.</p>		<p>Prior to occupancy days</p>
<p>Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.</p>	<p>PA Low</p>	<p>Policies and procedures guide staff processing linen to ensure the clean and dirty flow is maintained.</p> <p>A dedicated area within the facility is used to receive the dirty laundry to be washed. After washing, the laundry is transported across an external pathway to a clean room in an outside building, where it is dried and sorted. The clean laundry, ready to use, leaves the clean area through the same pathway to return to the main building for storage and distribution.</p> <p>The inspected external pathway has no protective cover from the weather. The clean laundry was transported in trolleys without watertight covers.</p>	<p>Clean laundry is transported without protective cover.</p>	<p>Ensure protection of clean laundry during transport.</p> <p>180 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.