The Ultimate Care Group Limited - Ultimate Care Palliser House

Introduction

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

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

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

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

The specifics of this audit included:

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: 15 June 2021 End date: 16 June 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: 27

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ultimate Care Palliser House can provide care for up to 32 residents requiring rest home, hospital (geriatric and medical) and dementia level care. There were 27 residents at that facility on the first day of the audit.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, review of resident and staff files, observations, interviews with residents, family, management, staff and general practitioners.

There are areas identified as requiring improvement relating to: Māori cultural support; open disclosure and neurological observations; quality data evaluation; staffing and skill mix care planning; wound care; activities; care documentation; medication; equipment; laundry services and emergency supplies.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Ultimate Care Palliser House has a philosophy to ensure that the residents' rights to privacy and dignity are recognised and respected at all times. Family/whānau involvement is encouraged in assessment and care planning, and visiting is encouraged.

The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights.

There is a Māori health plan and cultural safety policies that guide staff in cultural safety, including recognition of Māori values and beliefs. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

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

Ultimate Care Group Limited is the governing body responsible for the services provided at Ultimate Care Palliser House. The scope, direction, mission and goals of the organisation are documented.

The quality and risk management programme for Ultimate Care Palliser House includes the service philosophy, goals and a quality planner.

Ultimate Care Palliser House is managed by a qualified nurse manager who is responsible for facility management and the oversight of clinical service provision. The nurse manager is a registered nurse, who has been in this role for one year. The regional manager mentors and supports the nurse manager.

Quality activities are conducted and these generate improvements in practice and service delivery. Quality improvement initiatives are developed and implemented and discussed at relevant meetings.

Resident/relatives' meetings have been held, and residents and family are surveyed annually.

Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An education and training programme has been implemented with a current plan in place.

Appropriate employment processes are adhered to, and all employees have an annual staff appraisal completed. There is a roster tool that ensures sufficient and appropriate staff coverage for the effective delivery of care and support.

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 the resident's admission to the facility.

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

All residents' files reviewed demonstrated that evaluations were completed six-monthly or when the resident's condition changes.

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

An electronic medication management system is in place. Medications are administered by the registered nurse and health care assistants who have completed current medication competency requirements.

The activity programme is managed by an activity coordinator. The programme provides residents with a variety of individual and group activities and maintains their links with the community.

The food service meets the nutritional needs of the residents. All meals are prepared on-site. The service has a current food control plan. Kitchen staff have food safety qualifications.

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.

Ultimate Care Palliser House has a current building warrant of fitness. Waste and hazardous substances are managed safely.

A planned, preventative and reactive maintenance programme is in place that complies with legislation and includes but is not limited to equipment and electrical checks.

There are part time designated housekeeping and laundry staff. The laundry includes the safe storage of cleaning and laundry chemicals.

Residents' rooms are personalised to resident taste and are of sufficient space to allow for the safe use and manoeuvring of mobility aids.

There are sufficient communal areas within the rest home, hospital, and dementia areas that include lounge and dining areas. An external patio area is accessible for residents using mobility aids. The external gardens are accessible with suitable pathways. The external areas in the dementia units are secure and provide areas of interest.

The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted.

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.

Ultimate Care Palliser House has restraint minimisation and safe practice policies and procedures in place. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There were no residents requiring the use of a restraint or an enabler on the days of audit. Staff receive training around restraint minimisation and challenging behaviour.

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.

The infection control programme is appropriate to the size and complexity of the service. The infection control nurse is a registered nurse. Infection data is collated, analysed, and trended. Monthly surveillance data is reported to staff. 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	31	0	5	9	0	0
Criteria	0	78	0	5	10	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Ultimate Care Palliser House has policies and procedures that align with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Training on the Code is included as part of the orientation process for all staff employed and in ongoing training. Family and residents have been provided with information on admission which includes the Code. Interviews with residents and family demonstrated an understanding of the Code. Staff interviews confirmed that staff respect privacy, and support residents in making choices, where able.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	There are policies and procedures in place for informed consent and resuscitation. Completed resuscitation forms were evident on all resident files reviewed. In the case of clinically not indicated resuscitation status, there was evidence of GP involvement completed and signed. Two resident files reviewed in the dementia unit evidenced an approved needs assessment for the service and all included a nominated and enacted enduring power of attorney. General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent. Signed admission agreements were evident in

		the resident files sampled.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code pamphlets on entry. Interview with the management team confirmed practice. Residents and relatives interviewed identified that Ultimate Care Palliser House provides opportunities for the family/enduring power of attorney to be involved in decisions and that they are aware of how to access advocacy services. Resident files reviewed included information on resident's family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit, in accordance with the Covid-19 regulations. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events. The service provides assistance to ensure that the residents are able to participate in these as much as they wish and can do so safely. Resident/relative meetings are held two-monthly.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy in place. The complaints procedure is provided to residents and relatives on entry to the service. The nurse manager maintains a record of all complaints, both verbal and written, by using a complaint register. Documentation including follow-up letters and resolution, demonstrated that complaints are being managed in line with Right 10 of the Code. Five complaints have been logged, four in 2020 and one in 2021. All complaints are acknowledged, and a comprehensive investigation is completed, the complainant is kept informed if a lengthy investigation delays timeframes. A follow-up letter is sent to the complainant or a meeting is held to discuss the complaint and outcome of the investigation. Complaints all included a section to sign off on the register once resolved. There has been one complaint to the DHB (2021) concerning wound care which has been investigated and reported on internally by the head of clinical risk for the Ultimate Care Group. The DHB has followed up with the wound care clinical nurse specialist visiting and advising on wound care for this resident. Wound care training is planned for RNs and HCAs (July 2021). Wound care remains a concern for this facility (refer to 1.3.6.1).
Standard 1.1.2: Consumer Rights	FA	The information pack provided to residents on entry includes information on how to make a complaint,

During Service Delivery Consumers are informed of their rights.		and information on advocacy services and the Code. This information is discussed with residents and/or family members on entry to the service. Posters of the Code and advocacy information are displayed throughout the facility. The admission agreement includes information on the Code, the scope of services, and any liability for payment for items not included in the scope. Regular resident meetings provide the opportunity to raise issues/concerns. The nurse manager and administrator described discussing the information pack with residents and family members on admission.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Ultimate Care Palliser House has a philosophy that ensures the residents' rights to privacy and dignity are always recognised and respected. Residents are encouraged to maintain their independence. Outings are encouraged and supported for the residents who are able. Staff interviewed stated that they encourage the residents' independence by encouraging them to be as active as possible. During the audit, care workers were sighted knocking on resident's bedroom doors prior to entering and ensure doors are shut when cares are being given. Resident and relative interviews confirmed that privacy is being respected. Resident files reviewed identified that cultural and/or spiritual values and individual preferences were identified on admission with family involvement and these were documented in the residents' care plans. This includes cultural, religious, social, and ethnic needs. There are clear instructions provided to residents on entry and in their admission agreement, regarding responsibilities of personal belongings. The relatives interviewed stated their family was welcomed into the unit. Personal pictures were put up to assist them to orientate to their new environment. Interviews with the health care assistants (HCA) described how choice is incorporated into resident cares.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	PA Low	Ultimate Care Palliser House has a Māori health plan. There are implemented policies that identify culturally safe practices for Māori, including recognition of Māori values and beliefs, to guide staff in cultural safety. At the time of the audit there were three residents that identified as Māori. The files of the three residents were reviewed and these included information on tribal affiliations and cultural preferences. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Cultural needs are addressed in the care plan. However, cultural linkages have not been established. Cultural training is provided for staff. Health care assistants interviewed were aware of the importance of whānau in the delivery of care for Māori residents.

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Ultimate Care Palliser House recognises the cultural diversity of its residents, families, and staff. The facility's policies and procedures reflect key relationships with churches and community groups. Diverse beliefs, cultures, personalities, skills and life experiences are acknowledged. The residents' personal needs and values were identified on admission and this information is gathered from previous interRAI assessments and residents, family and/or enduring power of attorney. All care plans reviewed included the resident's social, spiritual and cultural needs. Health care assistants were able to give examples of how they meet the individual needs of each resident they care for. A newly commenced pastoral visitor (minister) is available to offer spiritual services for residents.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The service has organisation-wide policies and procedures to protect residents from any form of discrimination, coercion, harassment, or exploitation. Relevant policies and procedures have been implemented. Staff orientation and in-service education provide ongoing awareness around prevention of any discrimination, coercion, and harassment. The nurse manager, and HCAs interviewed, demonstrated a clear understanding of professional boundaries. Documented job descriptions describe the functions and limitations of each position. Family interviewed acknowledged the openness of the service and stated that staff were all approachable, and welcoming.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	There are comprehensive policies and procedures, and a staff training programme which covers all aspects of service delivery. An internal auditing programme is implemented. Staff interviews described an active culture of ongoing staff development with the Careerforce programme commencing. There are implemented competencies for HCAs and registered nurses (RN). There are clear ethical and professional standards and boundaries within job descriptions. Registered nursing staff are available 7 days a week, 24 hours a day. Each resident can choose to retain their own general practitioner (GP); however, most residents choose to utilise the facility's GP who visits on a regular basis and is available after hours by phone. Ultimate Care Palliser House has struggled to obtain GP services and continues to work with the district health board (DHB) and primary health organisations in the region to ensure this service. Physiotherapy and dietitian services are provided as needed following a referral. A podiatrist is on site every six weeks. The GPs reported during interviews that referrals to other services are timely and appropriate. The RNs have access to the DHB for external training sessions and study days. The service has links

		with the local community and encourages residents to remain independent.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Moderate	Policies and procedures relating to accident/incidents, complaints and open disclosure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. Electronic accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. However, relatives are not always kept informed. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The admission agreement lists interpreter services as an excluded service although this service has not been charged for at Ultimate Care Palliser House. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. Regular resident/relative meetings are held two-monthly.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Ultimate Care Palliser House is part of Ultimate Care Group Limited with the executive team providing direction to the service. The goals and direction of the service are documented in the annual business, and quality and risk plan. Oversight and management of the facility is provided by a nurse manager who is a registered nurse (RN) with eight years experience as an RN in aged care and has been in this management role for one year. The nurse manager is being mentored and supported by the regional manager who has 12 years management experience in aged care, and a newly appointed RN team leader who is a RN with eight years experience in aged care. Ultimate Care Palliser House provides residential services for up to 32 residents requiring rest home or hospital (geriatric or medical) and dementia level care. There are 22 dual-purpose rooms, and 10 dementia beds. On the day of audit there were 27 residents – 10 at rest home level care including 1 on respite care and 7 at hospital level of care, including 1 resident on an Accident Compensation Commission (ACC) contract, and 10 residents within the secure dementia unit. All hospital level residents reside in dual-purpose rooms (verified).
Standard 1.2.2: Service	FA	During a temporary absence, the RN team leader covers the nurse manager’s role with the support of

Management 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.		the regional manager.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	There are policies and procedures and associated implementation systems to ensure that the facility meets accepted good practice and are adhering to relevant standards, including standards relating to the Health and Disability Services (Safety) Act 2001. Policies are regularly reviewed at head office level and all are current. New policies or changes to policy are communicated to staff. There is an implemented annual schedule of internal audits. Areas of non-compliance from the internal audits include the implementation of a corrective action plan with sign-off by the nurse manager when it is completed. Discussions with the nurse manager, regional manager, RNs and HCAs confirmed that the quality programme is implemented, and results are communicated to staff and relevant people. However, analysis of trends and evaluation of outcomes requires improvement. Since the last audit a new manager's reflective report has been developed to capture quality improvement initiatives as a result of internal audit findings. Quality improvement initiatives include the incorporation of pastoral care services into the everyday life of the facility, falls reduction with sensor mats, resident weight loss assessments, the improvement of food services and a reduction in infections. Strategies to improve staff moral and move towards a stable staff have included the employment of a new nurse manager, activities part time coordinator, a RN team leader, and a part time cleaner/laundry person. Annual resident and relative satisfaction surveys were completed in 2020 with an average rating of 67% approval. Corrective action plans implemented for the resident satisfaction survey include the employment of a maintenance/ground's person with improvements to the garden environment and routine maintenance. Ultimate Care Palliser House had a trained health and safety officer, RN, who is now working part time and thus not able to meet the requirements of this role. The nurse manager is fulfilling the role until another RN can be trained and appointed. Ultimate Care Palliser House has recently moved staff meetings (five various meetings; quality, health and safety, HCAs, RNs, infection control and prevention) that were all held monthly into a comprehensive once monthly meeting for all staff (quality and staff meeting). Since this change there has been an increase in staff attendance. These meetings include (but are not limited to): quality,

		restraint, health and safety and infection control; care issues, staffing, maintenance, activities, cleaning and laundry, foods service, accident/incidents reporting, staff education and competencies, updated policy and procedures, and internal audit results and associated corrective actions. There is consultation and communication with residents/relatives and staff through regular meetings, newsletters and emails. However, discussions are not always followed up. Hazards are identified on hazard identification forms. The hazard register is relevant to the service and has been regularly reviewed and updated. Ultimate Care Palliser House collects information on staff accidents/incidents and provides follow-up where required.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate	Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been section 31 notifications reported for an episode of challenging behaviour, absconding by resident, which required police assistance, and a notification of the change in Nurse Manager. Public health authorities were notified of a gastroenteritis outbreak in 2020. Ultimate Care Palliser House documents and analyses accidents/incidents, unplanned or untoward events, and provides feedback to the service and staff so that improvements may be made. Individual incident reports are completed for each accident/incident, with immediate action noted and any follow-up action required. Accidents and near misses are investigated by the nurse manager and analysis of incidents occurs. The service collects incident and accident data and reports aggregated figures monthly to the quality and staff meeting. Electronic incident forms are completed by staff for resident accidents/incidents, and the resident is reviewed by the RN at the time of event. The form is forwarded to the nurse manager for final sign off. However, observations, assessments and GP instructions are not consistently completed. The HCAs interviewed could discuss the incident reporting process.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Moderate	There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Staff files reviewed evidenced implementation of the recruitment process, employment contracts and completed orientation. The service has an orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. A competency programme is in place. Core competencies are completed annually, and a record of completion is maintained (competency sighted in reviewed files included: manual handling, hand

		hygiene, cultural safety, fire and evacuation, and medication). File reviews evidenced that annual performance appraisals have been completed for staff employed greater than one year. A record of practising certificates is maintained. There is current two-year education programme in place for all staff. Education and training for clinical staff is linked to external education provided by the DHB. Registered nurse, specific training viewed included: syringe driver, first aid certificates and interRAI. There are two RNs who are interRAI qualified and all RNs have a current first aid certificate. However, there are no RNs with dementia related experience or education. In the dementia unit there are four HCAs who have completed New Zealand Qualifications Authority (NZQA) dementia unit standards, and two who have completed two of the unit standards. Not all staff working in the dementia unit have the required dementia unit standard training. Ultimate Care Palliser House have currently sourced a Careerforce assessor, with the regional manager being appointed to this role and aged care education (Careerforce) is in the process of being recommenced.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Moderate	Ultimate Care Palliser House policy includes the rationale for staff roster and skill mix, inclusive of a nurse manager's roster allocation tool to ensure staffing levels are maintained at a safe level. Interviews with residents, relatives and staff confirmed that staffing levels (inclusive of cleaning and laundry duties) are insufficient to meet the needs of residents. Rosters reviewed evidenced that staff were replaced when sick by other staff members picking up extra shifts including the nurse manager covering registered nursing shifts. The nurse manager works 40 hours per week Monday to Friday and is available on call for any emergency issues or clinical support. The RN team leader is a new role, yet to be fully established, with this role currently also covering RN shifts. A staff availability list ensures that staff sickness and vacant shifts are covered. The long shifts are covered by senior HCAs or an enrolled nurse with medication competencies. The nurse manager with the assistance of head office human resources staff is currently advertising for and recruiting for vacant positions. Ultimate Care Palliser House has had a rapid increase in resident numbers over the last year with a high turnover of staff. Initially the nurse manager's roster allocation tool was used and there was an addition of short shift HCAs to increase staffing levels on morning and afternoon shifts. This tool has not been continued to be updated as resident occupancy has increased over the last three to four months. This means that staffing for resident acuity; facility layout and housekeeping duties have not been accounted for or adjusted to meet resident needs. This tool was brought up to date by the regional manager during the audit and the increased staffing level adjustments noted. A part-time position for laundry (three hours) and cleaning (three hours) Monday to Friday was commenced on the week of this audit. Health care assistants continue with these duties throughout their shifts with night staff cleaning communal

		areas. The nurse manager is on site Monday to Friday. The facility has 24/7 RN cover. However, there is no appropriately trained or experienced RN (refer to 1.2.7.3), with designated responsibility for the oversight of the dementia unit. Staffing in the hospital/rest home includes: morning shift; a RN plus 2 HCAs from 7am to 3:30pm. Afternoon shift; a RN plus 1 HCAs from 3:30pm to 12am and a HCA from 4pm to 9pm. Night shift; a RN plus 1 HCAs from 12am to 7am. Staffing in the dementia unit includes: morning shift; an HCA or enrolled nurse from 7am to 3:30pm plus a HCA from 7am to 10am. Afternoon shift, a HCA from 3:30pm to 12am and a HCA from 5pm to 8pm. Night shift, an HCA from 12am to 7am.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner. All resident files are electronic. All staff have individual log-in details and access levels are assigned according to role defined guidelines. An external provider manages the database, back-up and security. Individual resident files sampled, demonstrated service integration. Medication charts are completed using a secure electronic management system. Electronic progress notes and care plans are in the electronic database and are legible, dated and identified to the relevant staff member including designation. The electronic systems are password protected.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Needs assessment and service coordination (NASC) assessments are completed for patient's entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the resident's level of care requirements. There is an information pack provided to all residents and their families prior to admission. Review of residents' files confirmed entry to service processes is implemented, ensuring compliance with entry criteria. Residents and family interviewed stated they were satisfied with the admission process and that it had been completed in a timely manner. Information about Ultimate Care Palliser House had been made available to them. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Transition, exit, discharge, or transfer is managed in a planned and coordinated manner. Interviews with RNs and review of residents' files confirmed there is open communication between services, the resident, and the family/whānau. Relevant information is documented and communicated to health providers. A transfer form accompanies residents when a patient is moved to another service or facility. Follow-up occurs to check that the resident is settled.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	The medication management policy was current and identifies all aspects of medicine management in line with the relevant legislation and guidelines. A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices are in line with legislation, protocols, and guidelines. The required three-monthly reviews by the GP or nurse practitioner were recorded electronically; however, resident allergies and sensitivities were not consistently documented. 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. There are no standing orders used at the facility. Review of the medication fridge evidenced that the service does not store or hold vaccines and interviews with the RN confirmed this. However, the medication refrigerator and drug room temperatures are not consistently monitored as per policy. 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 staff observed administering medication 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; however, documentation made regarding effectiveness is inconsistent both in the electronic system and in the progress notes. Pro re nata medications that are administered frequently are not reviewed to determine whether they should be prescribed on a regular basis (refer to 1.2.8.2). Medications to alleviate behavioural and psychological symptoms of dementia (BPSD) and PRN are prescribed regularly for residents in the secure dementia unit as evidenced by a review of medication charts. Six medication charts were reviewed, all evidenced medication charted for BPSDs. There had been two incidents in the week prior to the audit where residents had been administered medications

		which caused excessive sedation. Current medication competencies were evident in staff files. There were no residents self-administering medication on the day of the audit.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals are prepared on site and served in the dining rooms or in the resident rooms if requested. The seasonal menu has been reviewed by a dietitian, with the winter 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. Food temperatures are monitored appropriately and recorded. The kitchen staff have relevant food hygiene and infection control training. The kitchen was observed to be clean, and the cleaning schedules sighted. 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 six-monthly. Diets are modified as needed and the cook interviewed confirmed awareness of the dietary needs, likes and dislikes of residents. These are accommodated in daily meal planning. Residents were observed to be given sufficient time to eat their meal and assistance was provided when necessary. There were sufficient staff to ensure appropriate assistance was available. Residents and family interviewed stated that they were satisfied with the meals provided. 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.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is	FA	The service has a process in place if access is declined. When residents are declined access to the service, residents and their family/whānau, the referring agency and GPs are informed of the decline to entry. The resident would be declined entry if not within the scope of the service or if a bed is not available. A waiting list is maintained.

managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The initial nursing assessments which include dietary needs, pressure injury, falls risk and social history are completed using the electronic system. The initial care plan guides care for the first three weeks of the residents' admission. Registered nurses complete the interRAI assessment within the required timeframes. The long-term care plan is based on the interRAI assessment outcomes. Assessments are recorded, reflecting data from a range of sources, including: the resident; family/whānau; the GP/nurse practitioner and specialists. Policies and protocols are in place to ensure continuity of service delivery. All residents have current interRAI assessments completed by one of two trained interRAI assessors on site. Residents and family members confirmed involvement with the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	Long-term care plans are developed with resident and family/whānau involvement. However, these were not consistently developed within the required timeframes (refer to 1.3.3.3). Long-term care plans are developed from information gathered during the interRAI assessment. However, the interventions are not consistently recorded in sufficient detail to manage the assessed risk. Short-term care plans are developed for the management of infections and other acute issues. However, these do not contain interventions in sufficient detail to provide guidance for management of acute problems. Resident files are managed using an electronic system. Review of resident files showed service integration with clinical records, activities notes, and medical and allied health professionals' reports and letters all in electronic system. Interviews with residents confirmed that they have input into their care planning and review.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	Long-term care plans are completed by the RN and based on assessed needs, desired outcomes and goals of residents. However, not all long-term care plans contained interventions for management of needs identified during the assessment process (refer to 1.3.5.2). Short-term care plans are in place for all acute problems; however, interventions are not documented in sufficient detail to guide resident care (refer to 1.3.5.2). The GP documentation and records reviewed were current. The two GPs interviewed stated that there

		was good communication with the service and that they were informed of concerns in a timely manner. An after-hours service is provided. The physiotherapist visits the facility weekly and confirmed at interview that they review all new admissions, residents who have sustained a fall, and any residents referred by the RNs. Staff interviews confirmed that they are familiar with the needs of residents and that they have access to the equipment, supplies and products they require to meet those needs. There is evidence of wound care products available at the facility. A review of the wound care plans evidenced all wounds had a plan in place. However, wound care is not being carried out in accordance with policy or best practice. Additional specialist input has recently been sought for one resident with complex wounds. Monthly observations such as weight and blood pressure are completed and are up to date.
Standard 1.3.7: Planned Activities 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.	PA Moderate	The residents' activities programme is overseen by a diversional therapist from another Ultimate Care Group Limited facility. The activity coordinator works from 10am to 3:30pm on Tuesday, Wednesday and Thursday. On the remaining four days HCAs have responsibility for implementing the programme. The activities planning covers a seven-day period and the activities programme was displayed in the facility. However, the activity programme is not implemented during the days when the activities coordinator was off duty. The programme describes a variety of activities which incorporate education; leisure; cultural; and social events. Activities mainly take place in the dementia unit when the activity coordinator is on duty to enable all residents to participate. The residents' activities assessments are completed within three weeks of the residents' admission to the facility in conjunction with the admitting RN. Information on residents' interests, family and previous occupations is gathered during the interview with the resident and their family and documented. The residents' activity needs are reviewed six-monthly, at the same time the care plans are reviewed, and are part of the formal six-monthly multidisciplinary review process. For residents living in the secure dementia unit long-term care plans contain strategies for minimising episodes of challenging behaviours and a description of how the behaviour of the residents is best managed over a 24-hour period. There are additional nutritious snacks available for residents in the secure dementia unit over a 24-hour period.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Resident care is evaluated on each shift and reported at handovers. If any change is noted, this is reported to the RN. Long-term care plans are evaluated every six months in conjunction with the interRAI re-assessments or if there is a change in the resident's condition. Evaluations are documented by the RN. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Health care assistants document assistance given with activities of daily living in the progress notes. However, progress notes, including RN reviews do not reflect the resident's current acuity and record information for ongoing care. Residents and family interviewed confirmed involvement in the evaluation process and any resulting changes that occur.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other medical and non-medical services. Where needed, referrals are sent to ensure other health services, including specialist care is provided for the resident. Referral forms and documentation are maintained on resident files. Referrals are regularly followed up.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	The service has documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. Waste is appropriately managed. Chemicals were secured in designated locked cupboards. Chemicals were labelled, and safety datasheets were available and accessible to staff. Safe chemical handling training has been provided by the contracted supplier. Gloves, and aprons, are available, and staff were observed wearing personal protective equipment/clothing (PPE) while carrying out their duties. The maintenance person interviewed described the safe management of hazardous material.
Standard 1.4.2: Facility	FA	Ultimate Care Palliser House has a current building warrant of fitness, which expires on 30 June 2021.

Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		Hot water temperatures are checked monthly and were all under 45 degrees Celsius. There have been occasions when the hot water temperatures in resident areas are outside the 45 degrees requirements, corrective actions have been put in place. Medical equipment and electrical appliances have been tested and tagged and calibrated (due for review December 2021). There is a planned schedule to maintain regular and reactive maintenance and the maintenance staff interviewed could demonstrate progress. Residents were observed to mobilise safely within all areas of the facility. There are sufficient seating areas throughout the facilities with a variety of smaller and large lounge areas. The facility has no residents who smoke and staff have a small area outside for smoking away from the residents. Health care assistants interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs and as identified in the care plans. The gardens are maintained with safe paving, lawn and gardens. All communal areas both in and out of the building are easily accessible for residents using mobility aids. The secure outdoor area off the dementia unit is suitable for residents who wander or move in and out of the building.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	All resident rooms throughout the facility are single rooms, some with ensuites. Rooms provide adequate space for resident cares to be provided as sighted during the audit. In addition, there are communal mobility bathrooms, with showers and toilets, of sufficient size for mobility aids. These are located within easy distance of rooms that do not have ensuites. Visitor toilet facilities are available. Residents interviewed stated their privacy and dignity is maintained while attending to their personal cares and hygiene. The communal toilets are well signed and identifiable and include vacant/in-use signs. There are easy clean flooring and fixtures, and handrails are appropriately placed.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	The resident rooms are of sufficient size to meet the resident's assessed needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Health care assistants interviewed reported that rooms have sufficient room to allow cares to take place. The bedrooms were personalised to residents' taste.
Standard 1.4.5: Communal Areas For Entertainment, Recreation,	FA	Ultimate Care Palliser House has a large lounge and dining room and smaller lounge areas in rest home and hospital area. The dementia unit has a lounge and dining area. The dementia unit provides

And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		adequate space to allow maximum freedom of movement while promoting safety for those that wander, including dining and lounge areas. Dementia residents have access to a secure internal courtyard. The furnishings and seating are appropriate for the consumer groups. Residents interviewed reported they can move freely around the facility and staff assisted them when required. Activities take place in any of the lounges.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	PA Moderate	All linen and personal clothing is laundered on-site. There is a laundry situated in a small sluice room, which is used to store the cleaning equipment and cleaner's trolley along with clothing and linen waiting laundering. This area does not facilitate safe infection prevention control practice. The service has a newly purchased non-commercial washing machine which sits next to the soiled linen tubs. This machine has a capacity of 7-10kg and uses a cold or warm wash only. The contracted chemical provider had recently increased the amount of chemical supplied to each wash due to staining. Clean laundry is carried to a drying room (external to the building) which has a commercial dryer with adequate clean space for folding linen and resident's clothing before it is transported to the facility. A dedicated cleaning/laundry part time staff member has just commenced duty each weekday and HCAs also complete cleaning and laundry tasks (refer to 1.2.8). Audits of laundry/cleaning have not been undertaken. The cleaning chemicals are stored on the cleaning trolley during cleaning. However, chemical storage is not secure. Staff had to ensure that all laundry was completed to meet the needs of the next day, as there was insufficient linen supply.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	PA Moderate	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six-monthly fire evacuation drills take place. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. All supplies including food stores are checked monthly. However, there were inadequate supplies in the event of a civil defence emergency. There was an adequate supply of stored water and gas for cooking and water heating. Emergency management is included in staff orientation and ongoing as part of the education plan. A minimum of one person trained in first aid is available at all times. There are call bells in the residents' rooms and ensuites, communal toilets and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The building is secure after hours.

Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Ultimate Care 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 specialist advice from the DHB infection prevention and control nurse. A documented role description for the ICN is in place. The ICN has completed online infection prevention and control training through the Ministry of Health. The infection control programme is appropriate for the size and complexity of the service. The infection prevention and control programme is reviewed annually. Staff are made aware of new infections through daily handovers on each shift, 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.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The ICN is responsible for implementing the infection control programme. The nurse manager stated that there is adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the facility's quality and staff meetings. The ICN has access to all relevant resident data to undertake surveillance, internal audits, and investigations. Staff interviewed demonstrated an understanding of the infection prevention and control programme.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention	FA	The Ultimate Care Group Limited has documented policies and procedures in place that reflect current best practice relating to infection prevention and control. Staff were observed to be complying with the infection control policies and procedures. Staff demonstrated knowledge of the requirements of standard precautions and were able to locate policies

and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff education on infection prevention and control is provided by the ICN and external infection control specialists. All staff attend infection prevention and control training. Records of attendance are maintained. Staff interviewed confirmed their understanding of how to implement infection prevention and control activities into their practice.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The Ultimate Care Group Limited surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal infection prevention and control audits are completed. Infection data is collated monthly and is submitted to Ultimate Care National Support office. Monthly surveillance data is collated and analysed to identify any trends, possible aetiology and any required actions. This data is reported at the quality and staff meetings and displayed on the staff noticeboard. There has been one outbreak since the last audit. Review of documentation evidenced that this was managed and reported as required. Covid-19 information is available to all visitors to the facility. Ministry of Health information was available on site. Infection prevention and control resources were available should a resident infection or outbreak occur.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is the nurse manager, they provide support and oversight for enabler and restraint management in the facility. On the day of the audit, there were no residents using restraints or enablers. A similar process is followed for the use of enablers as is used for restraint use. Restraint is used as a last resort when all alternatives have been explored. This was evident from

		interviews with staff who are actively involved in the ongoing process of minimisation. Regular training occurs and review of restraint and enabler use is completed and discussed at all quality and staff meetings.

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)
Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.	PA Low	There is a cultural safety policy to guide practice, including recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of the audit there were three residents that identified as Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. However, there are currently no links established with community representative groups (Kaumatua/Māori staff), as requested by the resident/family.	There are no links with community representative groups or support available for residents who identify as Māori.	Ensure that those residents who identify as Māori have support links to their community established. 90 days
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Moderate	Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. Electronic accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Fifteen electronic accident/incident forms were reviewed (from May/June 2021)	Family/enduring power of attorney are not always informed when an accident/incident affecting the resident	Ensure that family/enduring power of attorney is contacted when a resident suffers an

		which identified relatives are not always (nine of fifteen) kept informed.	occurs.	accident/incident and that this is documented. 30 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality data is discussed at meetings, staff can describe the information discussed as per the minutes. However, the data although analysed does not address trends, and that outcomes are evaluated. Staff and residents reported corrective actions and improvements are discussed at meetings; however, there is no evidence of follow up of these discussions.	i) There is no evidence of trending of quality data or evaluation of outcomes. ii) Corrective actions discussed in staff and residents' meetings are not followed up.	i) Ensure evaluation outcomes and trending of quality data is documented. ii) Ensure corrective actions discussed at meetings are followed through and progress towards achievements are documented, discussed and evidenced in meeting minutes. 90 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service	PA Moderate	Policy defines the follow up and assessment following a resident incident or fall. A sample of 14 resident-related incident reports for May-June 2021 were reviewed. Incident reports and progress notes evidenced RN follow-up and residents with un-witnessed falls (7) did not always have neurological observations completed, and opportunities to reduce the future risks (where possible) have not always been identified. The GP is notified when required. However,	i) Neurological observations are not always completed, as per policy, following an un-witnessed fall or head injury.	i) Ensure neurological observations are carried out post un-witnessed falls or head

shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.		where GP instructions were required to be met following an accident/incident, these were not always documented as being followed up.	ii) Opportunities to reduce the future risks of a fall have not always been identified. iii) General practitioner instructions post accident/incident for monitoring/cares were not always documented as being followed up.	injury. ii) Ensure opportunities to reduce fall risk have been identified actioned and evaluated. iii) Ensure that GP instructions are followed up and documented. 30 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Moderate	Staff have access to a two-year education programme (January 2020 to December 2021). The HCAs undertake aged care education (Careerforce) which is in the process of being recommenced. However, there are staff members, who work in the hospital and rest home area and also staff in the dementia unit and have been employed for over eighteen months, who do not have NZQA dementia level standards nor are they enrolled in training.	i) The facility has no RN who has had experience and training in the care of older people with dementia and the ageing process. ii) Not all shifts in the dementia unit have staff rostered on duty who have commenced or completed the NZQA, dementia unit standard training.	i) Ensure that the dementia unit has access to a RN who has had experience and training in the care of older people with dementia and the ageing process. ii) Ensure that staff employed to work in the dementia unit are enrolled in or have completed the NZQA dementia unit standards

				training. 60 days
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Moderate	Register nurse cover is provided for the facility. However, there is no dementia trained/experienced RN. There is a rationale for staff roster and skill mix, inclusive of a nurse manager's roster allocation tool to ensure staffing levels are maintained at a safe level. This tool has not been updated to reflect increased resident occupancy over the last three to four months. As a consequence, staffing for resident acuity; facility layout and housekeeping duties have not been accounted for or adjusted to meet resident needs. This tool was brought up to date by the regional manager during the audit and the increased staffing level adjustments noted. A part-time position for laundry (three hours) and cleaning (three hours) Monday to Friday commenced on the week of this audit. However, HCAs continue to complete laundry and housekeeping duties throughout their shifts with night staff cleaning communal areas.	i) There is no RN with designated responsibility for the oversight of the dementia unit. ii) The nurse manager's roster tool does not reflect the increase in resident numbers and acuity. Consequently, there are gaps in staff levels and skill mixes with regard to HCAs actually required for resident care, and cleaning and laundry duties within shifts.	i) Ensure that there is an appropriately experienced RN designated with the responsibility for the dementia unit. ii) Ensure that as per policy the manager's roster tool is implemented to ensure that staff mix and skill levels are maintained to meet requirements and resident needs. 30 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing,	PA Moderate	An electronic system for medication management is used; however, in three out of twelve medication charts reviewed allergies and sensitivities were not recorded. There is a system for monitoring and recording temperature checks of the medication room and medication fridge. However, review of documentation evidenced that room and fridge temperatures were not consistently monitored and documented.	i) Resident allergies and sensitivities are not consistently documented on the electronic system. ii) Temperature monitoring of the	i) Ensure all resident allergies and sensitivities are documented on the electronic medication

dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.			medication room and medication fridge is carried out inconsistently.	system. ii) Ensure temperature monitoring of the medication fridge and medication room is carried out in accordance with policy. 60 days
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Moderate	Pro re nata medication administration is overseen by the RNs. However, effectiveness of PRN medications is not recorded consistently in the electronic system or in the progress notes.	The effectiveness of PRN medications is not documented consistently in the electronic system or in the progress notes.	Ensure the effectiveness of all PRN medications administered is documented. 60 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs	PA Low	Initial care plans are developed within the required timeframes. However, in two out of the six files reviewed the long-term care plan had not been developed within three weeks of admission. The GP or nurse practitioner visit residents every three months or more often if required. However, there is no documented evidence of the exemption from monthly visits when the resident's condition is considered stable in the clinical files reviewed.	i) Long-term care plans are not consistently developed within three weeks of admission. ii) There is no documentation of the exemption from monthly visits by the	i) Ensure that long-term care plans are developed within three weeks of admission. ii) Ensure that there is documented evidence of the

of the consumer.			GP/nurse practitioner when the resident's condition is considered stable.	resident's condition being stable to allow for three-monthly reviews by the GP or nurse practitioner. 90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	Long-term care plans are developed from information gathered in the interRAI assessment. However, interventions are not consistently documented in sufficient detail to guide residents' care. Initially six clinical records were reviewed but the sample was extended. In the original sample there were no interventions to manage pressure injury risk for the resident with an existing pressure injury. The sample was extended to include the two other residents with identified pressure injuries. The clinical files of these two residents did not describe individualised interventions for pressure relief and prevention. Short-term care plans are developed for acute problems using the electronic system. However, interventions were not documented in sufficient detail to guide care. When using the electronic system for the short-term care plans the user is required to select goals and interventions from 'drop down' boxes. In the short-term care plans reviewed the system had not been used correctly and only one intervention had been selected for each short-term care plans. For example, in a short-term care plan for managing a urinary tract infection, the intervention selected was pain management.	i) Long-term care plans do not contain sufficient information to address all residents assessed needs. ii) Short-term care plans do not contain sufficient information to guide resident care for acute problems.	i) Ensure that all long-term care plans contain sufficient detailed individualised interventions to manage residents' assessed risks. ii) Ensure that short-term care plans describe interventions in sufficient detail to manage acute problems. 90 days
Criterion 1.3.6.1 The provision of services and/or interventions are	PA Moderate	Wounds are assessed and documented in the electronic system. However, review of the 12 identified wounds evidenced that not all wounds were correctly assessed; for example, one wound which was described in documentation as a grade 1 skin tear, the photo	Wound care is not carried out in accordance with policy or best	Ensure that all wound care is carried out in accordance with policy and best

consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.		evidenced a large stage 3 skin tear. Timeframes for redressing wounds were not consistently adhered to, for example for one resident the wound plan stated that the wound was to be redressed every three days and on two occasions the wound had been redressed after an interval of more than five days. Another wound dressing was three days overdue on the day of audit. Measurements and photos were recorded inconsistently. Of the 12 wounds reviewed photos were taken for 2 wounds, 1 for each wound. No photos had been taken of the stage 3, stage 2, and 'sacral split' pressure injuries.	practice.	practice. 60 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	An activity coordinator develops the activity programme which is approved by a diversional therapist. Staff interviewed advised that the activities coordinator implements the activities as per programme on Tuesday, Wednesday, and Thursday. Interview with a family member who visits the facility daily indicated that activities did not occur on Friday, Saturday, Sunday or Monday. Staff interviewed confirmed that the activities did not occur due to their HCAs workloads (refer to 1.2.8.1).	Activities are not implemented as per approved activity programme.	Ensure that activities are implemented and documented as per activity programme. 60 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Progress notes contain details of assistance given with activities of daily living. However, in all clinical records reviewed, progress notes evidenced that visits from the GP were not documented, accidents and incidents were inconsistently documented and contact with family was not recorded. The required regular RN reviews were inconsistently documented and did not evidence comprehensive reports of residents' ongoing health status.	Progress notes, including RN reviews do not reflect residents' current acuity and record information for ongoing care.	Ensure all information regarding residents' health and progress is recorded in the progress notes. 90 days

Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.	PA Moderate	All linen and personal clothing is laundered on-site. There is a laundry situated in a small sluice room, which is used to store the cleaning equipment and cleaner's trolley along with clothing and linen waiting laundering. There is insufficient room for infection and control compliance in this small space. The sluice and soak tubs do not have anti-splash guards and staff had not been provided with face shields for safety. The sluice hose did not have a complete spray head which allowed for water to splash back when clothing or equipment was being sluiced. The cleaner's trolley was used by staff throughout the facility and had unsecured chemicals in spray bottles on top. Health care assistants and a newly appointed staff member carry out cleaning and laundry duties. However, cleaning and laundry audits have not been carried out. There was insufficient linen supply to meet the needs of the increased capacity of the facility, and staff had to ensure that all laundry was completed on the day to meet the needs of the next day.	i) Laundry equipment and room size did not meet the needs of infection control and prevention or the workload for the facility. ii) The sluice and hose did not give staff protection from splash back, with either a splash guard or face shield provided. iii) The cleaner's trolley had chemicals stored in an unsafe manner. iv) There was insufficient linen supply for the increase in resident numbers.	i) Ensure that the laundry equipment meets the requirements for a facility of 30 plus residents inclusive of infection control and prevention requirements. ii) Ensure that staff have adequate protection when handling soiled laundry. iii) Ensure that chemicals are stored securely on the cleaner's trolley. iv) Ensure there is a sufficient supply of linen. 60 days
Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and	PA Moderate	All emergency supplies including food stores are checked monthly. However, these had not been increased with the growth in resident occupancy.	There are insufficient emergency supplies to sustain staff and residents in an emergency situation.	Ensure there are sufficient supplies to ensure sustainability in an emergency situation.

security situations. This shall include fire safety and emergency procedures.				30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.