

The Ultimate Care Group Limited - Ultimate Care Aroha

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 Aroha
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 10 December 2019 End date: 11 December 2019
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:	44

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

The Ultimate Care Group Limited - Ultimate Care Aroha is part of the Ultimate Care Group Limited. The facility is certified to provide services for 48 residents requiring rest home, hospital or dementia level of care. There were 44 residents at the facility on the first day of the audit.

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

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

There was an area identified as requiring improvement at this audit relating to observations following falls.

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.		Standards applicable to this service fully attained.
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Information regarding the Health and Disability Commission Code of Health and Disability Consumers' Rights; the complaints process; and the Health and Disability Advocacy Service is made available to residents and their families on admission and is accessible in the facility.

Staff interviews demonstrated an understanding of residents' rights and their obligations. Residents and family/whānau members confirmed their rights are being met.

Residents' cultural and spiritual beliefs are identified on admission, and there is access to cultural and spiritual support if required. Informed consent is practised, and written consent is obtained when required.

Services are provided that respect the independence, personal privacy, individual needs, and dignity of residents. Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure that residents are free from discrimination, abuse and neglect.

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

There is a documented complaints management system that aligns with Right 10 of the Health and Disability Commission Code of Health and Disability Services Consumers' Rights. Complaints are investigated and documented, with corrective actions implemented where required. A complaints register is maintained. There has been one complaint to the Health and Disability Commissioner's office since the last audit.

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.		Standards applicable to this service fully attained.
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The Ultimate Care Group Limited is the governing body responsible for the services provided at this facility. The mission and values of the organisation are documented and communicated to all.

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

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

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

Human resource policies and procedures guide practice and there is evidence that human resource processes are being followed. There is a role specific orientation programme and ongoing training is provided.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. Staffing levels are adequate across the services and meet contractual requirements.

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

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents' records provided evidence they are assessed prior to admission to Ultimate Care Aroha, by the needs assessment service coordinators. Residents' needs are then assessed by the multidisciplinary team on admission. InterRAI assessments, other risk assessments, care plans, and evaluations are completed by registered nurses and overseen by the clinical services manager. Residents and their families confirmed they are informed and involved in care planning. Continuity of care is demonstrated in handovers, nursing clinical records and medical and allied health records. Short-term care plans are in place for the management of acute, short-term problems.

The diversional therapist, assisted by the cultural advisor, manages the activities programme, which provides residents with a variety of individual and group activities, including outings into the community.

Medicines management occurs in line with legislative requirements and guidelines. The service uses an electronic medicines management system. Staff responsible for medicines management have attended education and completed annual medication competencies. There were no residents self-administering medicines.

All food is prepared on site. The kitchen manager is responsible for overseeing the food services. Nutritional needs of residents are assessed on admission and additional requirements, including modified diets are met. The service has an approved templated food plan. Menus are reviewed by a dietitian. Residents interviewed confirmed satisfaction with the food service.

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

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

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

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The Ultimate Care Group Limited policies and procedures on restraint and enabler use are current. Policies reference best practice and legislation. The designated restraint coordinator and restraint committee oversee restraint minimisation and safe practice at the facility.

Enablers are used on a voluntary basis when residents request their use. Staff receive training on all required aspects of restraint and enabler use, the consideration of alternatives to restraint, and dealing with challenging behaviours. Staff demonstrate knowledge and understanding of the restraint and enabler processes. The service has an up-to-date restraint and enabler register.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection control management systems are in place to minimise the risk of infection to residents, visitors and staff.

The infection control nurse is responsible for the oversight and implementation of infection prevention and control at the facility. Infection control education is provided to staff at orientation and at ongoing education and training days.

The infection control surveillance is appropriate for the size and complexity of the service. Infection data is collected, collated monthly, analysed and reported at meetings and to the executive team.

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	44	0	0	1	0	0
Criteria	0	92	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The organisation has implemented policies and procedures to ensure that services are provided in a manner that is consistent with the Health and Disability Commission Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>All staff have received education on the Code as part of orientation and the mandatory annual education programme. Staff interviews confirmed their understanding of the Code and described practices that evidence an understanding of their obligations. Evidence that the Code is implemented in their everyday practice includes, but is not limited to: maintaining residents' privacy; providing residents with choices, (e.g. options for rising in the morning and bed times; meal and shower times; food times and desired menu decisions; clothing and activities; involving family/whānau and residents in decision making; and ensuring residents are able to practice their own personal values and beliefs.</p> <p>Resident and family/whānau interviews, as well as observation confirmed that services are provided in a manner that upholds resident dignity and maintains their privacy. Staff are respectful towards residents and their families and resident interviews confirmed they receive information relevant to their needs.</p>
Standard 1.1.10: Informed	FA	There is an informed consent policy to ensure that a resident who has the capacity/competence to

<p>Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>consent to a treatment or procedure, has been given sufficient information to enable that resident to arrive at a reasoned and voluntary decision. It provides guidelines for staff to ensure adherence to the legal and ethical requirements of informed consent and informed choice. The policy includes a definition of consent and procedures and how this will be facilitated and obtained.</p> <p>Verbal consent is expected for activities of daily living; and specific consent is sought for: end of life care; advance care planning; and a note recorded for resuscitation decision.</p> <p>Cultural considerations are identified such as family/whānau support and the involvement of family/whānau in decision making. The information pack provided on admission includes information regarding informed consent. The clinical services manager or registered nurse (RN) discuss informed consent with family/whānau and the resident during the admission process to ensure understanding.</p> <p>Staff receive orientation and training on informed consent and staff interviews confirmed they are aware of the informed consent process.</p> <p>There is a resuscitation order and advance directives policy to ensure that the rights of the resident are respected and upheld, and residents are treated with dignity during all stages of serious illness. The policy defines the procedure for obtaining an advance directive and who may or may not make an advance directive. File reviews demonstrated that advance directives and resuscitation orders are completed in accordance with policy.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>There is an advocacy policy for staff to follow to ensure the Code is upheld and residents have access to representation. It includes facilitating access to advocacy for a resident if required.</p> <p>Information regarding the availability of the Nationwide Health and Disability Advocacy Service is included in the information packs provided to residents and family/whānau on admission to the facility. Additional advocacy services brochures are also available at the entrance to the facility. The complaints policy also includes making residents aware of their right to advocacy when making a complaint.</p> <p>Interview with the FM confirmed that external advocacy services can be accessed if required. An external advocate, who chairs the resident meetings visits the facility, in particularly the dementia unit, on a regular basis and encourages residents to speak up at resident meetings about any issues or queries. This was confirmed at interview. The cultural advisor is also available to advocate on behalf of Māori residents.</p> <p>Interviews with residents and family/whānau confirmed that they are aware of the right to advocacy and that advocacy services/advocates are available.</p>

<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Observations and resident, family/whānau and staff interviews, confirmed that families are welcome in the facility, are free to visit at any time and residents have access to visitors of their choice. There are areas where a resident and family/whānau can meet in private.</p> <p>Interview with residents, families and staff confirmed that residents are free to leave the facility and do so, such as to be involved in family/whānau events and afternoon teas, visit local clubs and go shopping. A local companion driving service is available for outings into the community. The activities programme includes outings in the community to places of interest such as church services; shopping and visiting local gardens.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisation has a complaints policy and process to ensure that that complaints are managed in line with Right 10 of the Code. The complaint process is made available as part of the admission pack and explained by the FM on the resident's admission. The complaint forms are also available in resident areas in the facility.</p> <p>The FM is responsible for managing complaints. There had been five complaints over 2019. An up-to-date complaints register is in place that includes the name of the complainant; date the complaint is received; a description of the complaint; the date the complaint was responded to; and the date of the resolution as well as the date the complaint is signed off. In addition to the complaints register a flow chart of activities and dates relating to each complaint is maintained to confirm adherence to policy requirements. Evidence relating to each lodged complaint is held in the complaints folder and register. Interview with the FM and a review of complaints indicated that complaints are investigated promptly, and issues are resolved in a timely manner.</p> <p>Interviews with the FM, advocates, staff and residents confirmed that residents are encouraged to raise any concerns and provide feedback on services and this includes discussing and explaining the complaints process. Resident and family/whānau interviews confirmed that they are aware of the complaints process. Residents and family/whānau stated that they had been able to raise any issues directly with the FM and that these are dealt with efficiently and to their satisfaction.</p> <p>There has been one complaint relating to communication with family/whānau members since the last audit managed by the district health board (DHB). The facility had implemented the advice provided by the DHB, documented corrective actions implemented and the complaint had been closed. In addition, there has been one complaint to the Health and Disability Commissioner (HDC) since the previous audit, relating to resident care following a fall. The UCG national support office (NSO) has provided a response to HDC and is awaiting the outcome.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>New residents and their families are provided with information about the Code as part of an information pack provided on admission to Ultimate Care Aroha. The pack and admission agreement include information on the complaints process and the advocacy service. The facility manager (FM) explains the Code during the admission process to ensure understanding.</p> <p>The Code and associated information are also available in information brochures which are displayed throughout the facility and available to take away and read in private. Information on the Code is also displayed on posters in English and te reo Māori at the entrance and within resident areas in the facility.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The organisation has policies and procedures that are aligned to the requirements of the Privacy Act and Health Information Privacy Code, to ensure that a resident's right to privacy and dignity is upheld. They provide guidelines for respecting and maintaining privacy and dignity.</p> <p>Resident, family/whānau and staff interviews, and observation confirmed that: staff knock on bedroom and bathroom doors prior to entering; ensure that doors are shut when personal cares are being provided and residents are suitably attired when taken to the bathroom. Interviews and observation confirmed that staff maintain confidentiality and are discrete, holding conversations of a personal nature in private. Residents and family/whānau members' interviews confirmed that resident privacy is respected.</p> <p>The organisation has a policy on sexuality and intimacy that provides guidelines for managing expressions of sexuality. Staff interviews confirmed that they assist residents to choose the clothing they wish to wear. Resident and family/whānau interviews and observation confirmed that residents can choose what clothing and adornments to wear each day, including makeup, if that is their preference.</p> <p>Residents' files reviewed, staff and family/whānau interviews and observation confirmed that individual cultural, religious, social preferences, values and beliefs are identified, documented and upheld.</p> <p>There is policy that defines the guidelines and responsibilities of staff for reporting suspected abuse. It includes definitions of abuse and guidelines for managing abuse. Staff receive orientation and mandatory annual training on abuse and neglect. Staff interviews confirmed staff awareness of their obligations to report any incidences of suspected abuse or neglect. Staff and family/whānau interviews confirmed that there was no evidence of abuse or neglect. There were no documented incidents of abuse or neglect.</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	<p>FA</p>	<p>The organisation has a Māori health plan that identifies how the Ultimate Care Group Limited (UCG) will respond to Māori cultural needs and Māori beliefs in relation to illness.</p> <p>Staff receive training in cultural safety and values at orientation, as well as part of the mandatory annual education programme.</p> <p>At the time of the audit approximately one third of residents identified as Māori.</p> <p>The facility has one staff member employed as an assistant diversional therapist/cultural advisor, who is fluent in te reo Māori and provides cultural advice and support to resident families and staff. Interview with the assistant diversional therapist/cultural advisor described how cultural support is provided to Māori families and residents to welcome and help them settle into the facility.</p> <p>There are monthly facility visits to the local Marae day programme for those wishing to attend and family/whānau can accompany for support. Māori celebrations such as Matariki are incorporated into activities and facility events. Interviews with staff confirmed that the facility meet the cultural needs of Māori, including in death and dying. Blessing of a room by an appropriate person, is always under taken following the death of a resident and in the case of a Māori, this can also be performed by family/whānau.</p> <p>Staff interviews confirmed awareness of the importance of involving family/whānau in the delivery of care.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>There is a cultural safety policy that describes the procedure for identifying and meeting cultural needs, as well as physical, spiritual and psychological needs. It includes culturally sensitive considerations and practices.</p> <p>Staff and family/whānau interviews confirmed that residents are provided with choices regarding their care and the services provided, and that residents and family/whānau are involved in assessment and care planning processes.</p> <p>Information gathered during assessments includes identifying a resident's specific cultural needs, spiritual values, and beliefs. Assessments also include obtaining background information on a resident's spiritual and cultural preferences, which includes, but is not limited to: beliefs; cultural identity; and spirituality. This information informs care planning and activities that are tailored to meet identified needs and preferences. To foster a sense of cultural identity for Māori residents, assessments also include obtaining a detailed Whakapapa from those who wish to provide it.</p> <p>The cultural safety policy includes consideration of spiritual needs in care planning. For residents who</p>

		<p>chose to attend, there are regular religious services available twice a week. as the organisation also facilitates attendance at church services outside the facility. In addition, there are church affiliated lay persons who visit the facility to provide communion to those residents who wish to receive this. Observation and interview with a pastor, identified that services are held in the dementia unit to facilitate attendance by residents. Both spiritual leaders/pastors and the facility cultural advisor are available to provide room blessings when required.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>There are policies and processes to ensure that the environment for residents is free from discrimination; coercion; harassment; and financial exploitation. They provide guidance for staff how this will be prevented and, where suspected, reported.</p> <p>Job descriptions include the responsibilities of the position, including ethical issues relevant to each role. Staff interviews confirmed awareness of their obligation to report any evidence of discrimination, abuse and neglect, harassment and exploitation.</p> <p>There were no documented complaints or incidents recorded since the previous audit relating to any form of discrimination, coercion or harassment.</p> <p>Staff are required to sign and abide by the UCG code of conduct and professional boundaries agreement. Staff mandatory training includes professional boundaries. Staff interviews confirmed their understanding of professional boundaries relevant to their respective roles. Interviews with residents and families confirmed that these are maintained by staff.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	FA	<p>The facility implements the UCG policies and procedures, which are current, based on good practice, current legislation and guidelines. The policies align with the Health and Disability Services Standards and ensure safe, current evidence-based practice.</p> <p>There are relevant training programmes for all staff.</p> <p>The facility's data is entered onto the UCG electronic database and monthly reports in graph format are produced for the facility on performance. The regional manager reviews all data regularly. The regional manager's office is at the same address as the facility and is available to support the facility management team. The regional manager spends one day at least every two weeks at the facility, where required performance measures and data are discussed. Staff interviews, and monthly meeting minutes identified that monthly performance data is made available to, and discussed with, staff.</p> <p>Staff, resident and family/whānau interviews, residents' file notes and observation of service delivery confirmed that resident care is based on good practice guidelines.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The organisation has an open disclosure policy that promotes a transparent, consistent approach to full and open disclosure where there is an instance of actual or potential adverse event and or harm during the course of a resident's care. Completed incident forms, residents' records and resident and family/whānau interviews demonstrate that family/whānau are always informed if the resident has an incident/accident; a change in health or a change in needs. Family/whānau contact is recorded on incident forms and in residents' files.</p> <p>The resident admission agreement signed by the resident or enduring power of attorney (EPOA), confirms for residents, what is and what is not included in service provision.</p> <p>Staff, resident and family/whānau interviews confirmed that family/whānau are included in resident care planning meetings. Two monthly resident meetings inform residents and families of facility activities. All /family/whānau are welcome to attend meetings. Meetings are advertised on the facility notice board, in the activities planner, monthly newsletter and through personal reminders by staff. Meetings are chaired by an independent advocate, with presentations from the diversional therapist and the FM. Meeting minutes, interviews and observation demonstrate attendance by residents and families. Resident meetings also offer an opportunity to provide feedback and make suggestions for improvement as well as raise and discuss issues/concerns with management. Minutes of the family/whānau meetings sighted evidence that a wide range of subjects are discussed. Copies of the meeting minutes are provided to residents on the notice board. Copies of the activities plan and menu are also available to residents and families.</p> <p>Resident and family/whānau interviews confirmed that the FM and staff are approachable and available to discuss queries and issues. Interviews with residents and family/whānau identified the management team address concerns and queries promptly and proactively.</p> <p>There are policies to ensure that information is supplied in a way that is appropriate for the resident and/or their family/whānau and where required interpreters and cultural representatives/advocacy services are accessed to ensure information is understood. Interview with the FM confirmed that external interpreter services are available, if required. Staff represent a number of ethnicities and can communicate with residents in their native dialect if the resident wishes, such as: Māori; Pacifica and Hindi. At the time of the audit there were no residents who required an interpreter.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are</p>	<p>FA</p>	<p>There is a quality and risk management document that outlines the mission and values as well as detailing the business planning objectives of the organisation. The values and mission statement are displayed at the entrance to the facility and are communicated to all concerned through the facility's information pack provided to residents and their families on admission. Staff receive this information at</p>

<p>planned, coordinated, and appropriate to the needs of consumers.</p>		<p>orientation.</p> <p>The facility is part of UCG with the executive management team providing support to the facility. In the month prior to the audit, UCG had implemented an organisational restructure and the FM now reports to a regional manager, who is responsible for both regional quality and operational matters. Communication between the facility and UCG executive management occurs regularly with both the general manager clinical services and the regional manager providing support during the audit.</p> <p>The facility provides ongoing electronic reporting of events and occupancy into the UCG's national system that facilitates review of progress against identified indicators by the executive management team. A monthly report in graph format is provided to the facility, who then adds commentary to report back to the regional manager. A sample of monthly reports to the regional manager and national office showed information that monitors the service's performance including: admissions and discharges; financial performance; and staffing; as well as key indicators such as: compliments and complaints, health and safety; training and competencies. Benchmarking against other UCG facilities occurs at a national level.</p> <p>There is a current facility specific business plan that includes: finance; refurbishment; resident care; operational activities and staff.</p> <p>The facility is managed by a FM, with 40 years of experience in the health sector in New Zealand and overseas, including facility management and nursing education. The FM is a RN and has been in this position for two years. Clinical care at the facility is overseen by the clinical services manager (CSM), who is a RN with seven years' experience in primary health and has been in this role for five months. Both the FM and the CSM have completed a role specific orientation.</p> <p>The facility is certified to provide rest home care and hospital level care for up to 32 residents and dementia level care for up to 14 residents. There were 44 beds occupied at the time of the audit and included: 11 residents who had been assessed as requiring rest home level care; 19 assessed as requiring hospital level care and 14 residents assessed as requiring dementia level care. Included in the total occupancy numbers was one resident under the age of 65 years under the long-term chronic conditions contract who was assessed as requiring dementia level of care.</p> <p>The facility has contracts with the district health board for the provision of rest home, hospital and dementia level care; respite/day care; chronic long-term conditions and young persons with disability.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-</p>	<p>FA</p>	<p>During a temporary absence of the FM, the CSM, with support from the regional manager, is responsible for the day to day operation of the service.</p> <p>In the absence of the CSM, a RN with support from the regional manager will ensure continuity of</p>

<p>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>		<p>clinical services.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The facility utilises UCG's documented quality and risk management framework, this is available to staff to guide service delivery. Policies and procedures align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. The Ultimate Care Group Limited's management group reviews all policies with input from relevant personnel. Staff have electronic access to policies and procedures via UCGs internal network. New and revised policies are presented to staff and staff interviews confirmed that they are made aware of these.</p> <p>Quality improvement, risk management, clinical indicators and corrective actions arising from quality improvement activities are discussed at monthly meetings. Meeting minutes evidenced that all aspects of: quality improvement; risk management; and clinical indicators are discussed. Copies of meeting minutes are available in the staff room for all staff to review, including those who were unable to attend a meeting.</p> <p>The service delivery is monitored through the organisation's reporting systems, utilising several clinical indicators such as: falls; infections; health and safety; pressure injuries; skin tears; infections; falls; and medication errors.</p> <p>There is evidence that the annual internal audit programme is implemented as scheduled. Quality improvement data sighted, provided evidence that data is being collected and collated with the identification of trends and analysis of data. Corrective action plans are developed, implemented, evaluated and signed off where required. There is communication with staff of any subsequent changes to procedures and practice through monthly meetings and the electronic staff duty signing on system.</p> <p>Satisfaction surveys for residents and family/whānau are completed as part of the annual internal audit programme. Preliminary results of the recently collated survey reviewed, evidenced satisfaction with the services provided. This was confirmed by residents' and family/whānau interviews.</p> <p>The organisation has a risk management programme in place that records the management of risks in clinical, environment, human resource and other areas specific to the facility. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Staff interviews confirmed an awareness of health and safety processes and described an environment that encourages the reporting of hazards, accidents and incidents promptly. Health and safety events such as: incidents and accidents; hazard</p>

		<p>identification; emergency policy; health and safety projects and initiatives; education and orientation; infection control issues; new equipment; internal audits; and laundry are discussed at health and safety meetings.</p> <p>There are two elected health and safety representatives, who have both completed on-line training for health and safety managers and officers. Health and safety representative interviews confirmed a clear understanding of the obligations of the role and health and safety, including their role in staff orientation.</p> <p>Hazard reporting forms and staff interviews confirmed that hazard reporting is actively encouraged. There is evidence that identified hazards are addressed promptly and risks minimised. A current hazard register is available, and this is reviewed at least annually. Staff interviews confirmed that new hazards are reported and addressed promptly.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The FM is aware of situations which require the facility to report and notify statutory authorities, including: unexpected deaths; police involvement; sentinel events; infectious disease outbreaks and changes in key management roles. Interviews confirmed that these are reported to the appropriate authority by the UCG NSO. There was evidence that HealthCERT were notified of the appointment of the FM into a temporary dual role of CSM, until an interim CSM was appointed, with this role also notified when filled and notification to HealthCERT when the current CSM was appointed.</p> <p>Interviews with staff and review of adverse event forms confirmed that all staff are encouraged to recognise and report adverse events. Staff interviews confirmed an understanding of the adverse event reporting process and their obligation to document all untoward events. A review of staff records demonstrate that staff receive education at orientation on the incident/accident reporting process and this is reiterated at staff meetings.</p> <p>There is an implemented incident/accident reporting process and incident/accident reporting forms are available on the notice board in the staff room. Interviews with staff and review of documentation evidenced that staff document adverse, unplanned or untoward events on an incident/accident form, which is signed off by the FM. These are entered into the national incident reporting data base. Incident/accident reports selected for review evidenced that assessments and observations are completed (refer to 1.3.3). There is evidence of a corresponding note in the resident's clinical records and notification of the resident's nominated next of kin where appropriate.</p> <p>Corrective actions arising from incidents/accidents are implemented for resident and staff incidents/accidents. Information gathered is shared at monthly meetings with incidents/accidents graphed, trends analysed and benchmarking of data occurring. Specific learnings and results from incidents/accidents inform quality improvement processes and are regularly shared at the combined</p>

		staff, quality and infection control, health and safety and staff meetings.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position are documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; a signed employment agreement; position specific job description; and police vetting. An appraisal schedule is in place and all staff files reviewed for staff employed longer than one year evidenced a current performance appraisal.</p> <p>There is a system to ensure that annual practising certificates and practitioners' certificates are current including: RNs; general practitioners; nurse practitioners; physiotherapist; podiatrist; pharmacists; and dietitian.</p> <p>An orientation/induction programme is available, that covers the essential components of the services provided. It requires new staff to demonstrate competency on a number of tasks, such as: personal cares; manual handling; hoist and hoist policy; hand hygiene and restraint. Competencies are reviewed and assessed annually. Staff working in the dementia unit receive orientation specific to the requirements of working in the unit. Interviews confirmed that new staff are supported and buddied for at least three days or until competent and confident during their orientation into their new roles.</p> <p>A review of the management system confirmed that processes are in place to ensure that staff complete required training and competencies at the scheduled time.</p> <p>The organisation has implemented the UCG documented role specific mandatory annual education and training modules. There is an electronic data base to record and track staff training/education. Education session attendance records evidenced that ongoing education is provided, and staff have undertaken a minimum of eight hours of relevant training. In addition, 11 care givers have completed the Career Force dementia specific training or equivalent, and the other 6 are in the process of training.</p> <p>Six of seven RNs have completed interRAI assessments training and competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or</p>	FA	<p>The organisation's allocation of staff and duty roster policy requires a base roster be set according to the needs of the client groups, individuals and numbers. Staff hours are required to be set to ensure that they are sufficient to provide safe care in a timely manner, taking into account dependency levels and time required to provide care. A base roster is developed, and reviewed to accommodate anticipated workloads, identified numbers of residents to ensure safe staffing levels within the facility are sufficient to meet the needs of residents' acuity and the minimum requirements of the DHB</p>

<p>experienced service providers.</p>		<p>contract.</p> <p>The rosters evidence most staff working set shifts, on a rotational four-week cycle, with staff negotiating changes with colleagues. Rosters are confirmed and made available to staff one month in advance. There is a roster committee of care givers to work through care giver rosters. Staff interviews report a high level of satisfaction with both the flexibility and predictability of rostering. Staffing levels are reviewed to accommodate anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in residents' needs. There are sufficient RNs and care givers available to safely maintain the rosters for the provision of care to accommodate increases in workloads and acuity of residents.</p> <p>The facility includes three resident wings around a central courtyard, which includes a secure dementia unit. There is a centrally located nurses' station. Hospital level residents assessed as higher acuity are in rooms close to the nurses' station. In addition to the FM and the CSM who are on duty on the morning shifts from Monday to Friday, there is at least one RN for the facility on each duty seven days per week. There is an additional RN on morning duty, four days a week. In the dementia unit there are two care givers on morning duty and afternoon duty and one on night duty, seven days a week. For the dual-purpose wings there are two care givers on morning duty and afternoon duty and one on night duty, seven days a week. In the advent that additional RN support is required on night duty, the on-call FM or the CSM is called. The FM and CSM share on call after hours, seven days a week.</p> <p>Rosters sighted reflect adequate staffing levels to meet resident acuity and bed occupancy as per the requirements of the aged residential care contract.</p> <p>There are 63 staff, including: the management team; administration; clinical staff; diversional therapist, activities assistant; maintenance and household staff. Household staff include cleaners, laundry assistants and kitchen staff who provide services seven day a week.</p> <p>Observation of service delivery confirmed that residents' needs are being met in a timely manner. Family/whānau and resident interviews stated that staffing is adequate to meet the residents' needs. Staff interviews confirmed that they have sufficient time to complete their scheduled tasks and resident cares over their shift.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and</p>	<p>FA</p>	<p>Residents' records are maintained in hardcopy with electronic medication charts in use. Residents' information, including clinical records, are legible and entered into the resident's record in an accurate and timely manner, identifying the name and designation of the person making the entry. Residents' clinical records are completed every shift, detailing resident response to service provision.</p> <p>There are policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff interviews confirmed an awareness of their obligations and the procedures for</p>

<p>accessible when required.</p>		<p>maintaining confidentiality of resident information. Resident care and support information can be accessed in a timely manner and is protected from unauthorised access by being locked away when not in use. Archived records are securely stored on-site, until being archived at a later date off-site. Archived records can be retrieved if required. Documentation containing sensitive resident information, is not displayed in a way that could be viewed by other residents or members of the public.</p> <p>Each resident's information is maintained in an individual, uniquely identifiable record. Records include information obtained on admission, with input from the resident's family/whānau and resident where applicable.</p> <p>The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. Electronic medication charts are kept separate from residents' files and are accessible by authorised personnel only.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The Needs Assessment and Service Coordination (NASC) assessments are completed for entry to the service. All resident files reviewed had current interRAI assessments in place. There is an information pack provided to all residents and their families prior to admission. Review of residents' files confirmed entry to service complied with entry criteria.</p> <p>Interviews with residents and families and review of records confirmed the admission process was completed in a timely manner.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge, or transfer is managed in a planned and coordinated manner.</p> <p>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.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice</p>	<p>FA</p>	<p>There are policies and processes that describe medication management that align with legislation, policy and guidelines. Medicines are delivered in a pre-packed delivery system. Medications are checked against the resident's medication profile on arrival from the pharmacy by a RN.</p> <p>Review of the medication areas evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The drug register is maintained and evidenced weekly checks and six-monthly physical stocktakes.</p>

<p>guidelines.</p>		<p>An electronic medication management system is used at the facility and meets the current legislative requirements and safe practice guidelines. The medication rounds observed during lunch evidenced compliance with legislation and safe practice guidelines. Administration and specimen signatures are maintained. Interviews with RNs confirmed there are no standing orders being used at the facility.</p> <p>All staff authorised to administer medicines have completed current competencies. Staff education in medicine management is provided. The medication refrigerator temperatures are monitored, recorded weekly and are within the recommended range.</p> <p>There were no residents self-administering medicines.</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 food is prepared onsite. The kitchen manager (KM), who is also a chef, is responsible for the food services and is supported by two cooks and two kitchen assistants. Cooks cover the KM/chef's days off and any planned leave. The food service is in line with recognised nutritional guidelines for older people.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration is displayed. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen was observed to be clean, and all food was stored off the floor.</p> <p>The kitchen cleaning schedules and equipment is maintained. Kitchen staff complete an orientation and relevant food safety training. Food observed in the chiller was covered and dated. The service has a four weekly seasonal menu, approved by a dietitian at organisational level. Diets are modified as required. At interview, the KM/chef reported the RNs complete each resident's nutritional profile on admission, with the assistance of the resident and family/whānau. The kitchen is informed of any changes. Special diets are catered for and documented in the kitchen. Modified equipment, to meet residents' nutritional needs, is available. Food temperatures are monitored. Food is provided in a bain-marie to the dementia unit, where it is served to residents. Snacks and drinks are made available to residents in the dementia unit at all times of the day and night, to allow residents who wish to have a snack, may access food.</p> <p>Residents requiring assistance to eat, and drink are supported. The service encourages residents to express their likes and dislikes. The residents and families interviewed stated that staff ask them about their food preferences and they have opportunity to participate in food surveys.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service has a process in place if access is declined, should this occur. When residents are declined access to the service, residents and their family/whānau, the referring agency, general practitioner (GP) and/or nurse practitioner (NP) 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 was not available.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The initial nursing assessment and care plan is completed within 24 hours of admission. The initial care plan guides care for the first three weeks, with RNs completing the interRAI assessment. 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 or NP and specialists.</p> <p>Review of wound care documentation showed all wounds including skin tears are recorded on short-term care plans. Policies and protocols are in place to ensure continuity of service delivery. Assessment tools are reviewed at least six-monthly, including: falls; dietary; continence; and pain assessments. Residents interviewed confirmed assessments are completed according to their needs and in the privacy of their bedrooms. Interviews with residents and families confirmed their involvement in the assessments, care planning, review, treatment, and evaluation of care.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Long-term care plans are developed with the resident and family/whānau involvement. Short-term care plans are developed for the management of acute problems. All residents' files sampled had individualised long-term care plans meeting the needs of the residents. Care plans showed service integration with clinical records, activities notes, and medical and allied health professionals' notes and letters. Interviews with residents confirmed they have input into their care planning and review, and that the care provided meets their needs.</p> <p>Review of residents' records showed that the resident under the young person with disability contact participates in care planning, with their plan included activities to ensure their wellbeing, community participation and interventions to meet their physical, health and wellbeing needs.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and</p>	FA	<p>Review of residents' care plans showed detailed interventions based on assessed needs, desired outcomes and resident's goals. The GP and NP documentation and records reviewed were current.</p> <p>Interviews with residents and families confirmed that the current care and treatment needs were being</p>

appropriate services in order to meet their assessed needs and desired outcomes.		met. The service maintains family/whānau communication records in the residents' files. Staff interviews confirmed they are familiar with the needs of the residents. Residents can maintain links with other services.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The facility provides an activities programme which reflects the residents' goals, ordinary patterns of life, and includes community activities. Residents' files reviewed showed evidence of their social history. Residents' preferred activities are identified on admission. The diversional therapist, with input from the cultural advisor, plans and oversees the monthly programme. The activities programme is made available to residents and their families.</p> <p>Residents may choose whether they wish to participate in the group activities. Their participation in a daily exercise programme was evidenced during audit days. Residents are encouraged to maintain links with the community through outings. Birthdays and other special days are celebrated. Residents who prefer to stay in their room can have one-on-one visits including reading, hand massage and listening to music. Residents in the dementia unit have 24-hour behaviour management plans to assist staff in the identification and de-escalation of behaviours that may be challenging.</p> <p>Residents' attendance and participation is documented. Outcomes against goals are recorded. Evaluations are completed six-monthly with nursing review. There is evidence of resident and family/whānau participation. Regular resident meetings are held and include discussion around activities. The residents and their families reported satisfaction with the activities provided. Younger persons, with disabilities can choose activities of their preference from a range of opportunities. The diversional therapist ensures the implementation of activities in the dementia unit is occurring.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the clinical records (refer to 1.3.3.3). When changes are noted it is reported to the RN.</p> <p>Care plan evaluations, following reassessment, to measure the degree of a resident's response in relation to desired outcomes and goals, occurs six-monthly. Where progress is different from expected, the service develops a short-term care plan for the management of short-term acute problems. This includes problems such as infections, wounds, and falls. Short-term care plans, including wound care plans, are reviewed. Interviews with residents and family/whānau confirmed they are kept informed.</p>
Standard 1.3.9: Referral To Other Health And Disability Services	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

<p>(Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>forms and documentation are maintained on resident files. Referrals are regularly followed up. Communication records reviewed in the residents' files, confirmed family/whānau are kept informed of the referral process.</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>FA</p>	<p>Documented policies and procedures for the management of waste and hazardous substances are in place. Policies and procedures specify safety requirements that comply with legislation, including the requirements for clear labelling, disposal of and collection of waste. The hazard register is available and current.</p> <p>Current material safety data posters are available and accessible to staff in relevant places in the facility, for example, the sluice and cleaning cupboard. The product supplier provides both on-line and on-site training in the safe use of chemicals. Where required, one-on-one training is provided to individual staff members. The supplier visits the facility at least once a month to complete functionality checks of all equipment where products are being used, discuss the use of chemicals and check compliance, in the use of chemicals such as bottle labelling and cleanliness.</p> <p>Staff receive training and education in waste management and infection control as a component of orientation and mandatory training.</p> <p>Interviews and observations confirmed that there is enough personal protective clothing and equipment provided, such as aprons, gloves and masks. Interviews confirmed that the use of personal protective clothing and equipment is appropriate to the recognised risks. Observation confirmed that personal protective clothing and equipment was used in high-risk areas.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed in the entrance to the facility. Buildings, plant, and equipment comply with relevant legislation.</p> <p>A preventative and reactive maintenance schedule is implemented. This includes monthly maintenance checks of all areas and specified equipment such as hoists. Staff raise issues directly or identify maintenance issues in one of two maintenance log books. These are reviewed daily by the maintenance person. Urgent requests are attended to as required. A review of maintenance requests and interviews confirmed staff awareness of the processes for maintenance requests and that repairs are conducted in a timely manner.</p> <p>Interviews with staff and visual inspection confirmed there is adequate equipment available to support</p>

		<p>care. The facility has an annual test and tag programme that is up to date. Evidence of checking and calibration of biomedical equipment was sighted. There is a system to ensure that the facility van that is used for residents' outings is routinely maintained. Van cleaning is undertaken by the maintenance person. Safety checks are undertaken and include for example: tyres; water; and oil. Both the diversional therapist and the maintenance person who drive the van, have been assessed as competent to use the van hoist by a physiotherapist. There are systems in place to ensure that the van has a current registration and warrant of fitness. Interviews with staff and documentation evidenced that those staff who drive the van have a current driver's licence.</p> <p>Hot water temperatures are assayed monthly and are maintained within recommended temperature ranges. A review of temperature assays and interview with the maintenance person confirmed that where hot water temperatures have been above the recommended safe temperature, action is taken. Interview confirmed that rechecking of the temperature occurs until there is assurance that a safe temperature is being maintained. Hot water assaying is included within internal audit schedule.</p> <p>All resident areas can be accessed with mobility aids. There is a secure fenced area and an internal courtyard that are accessible from the dementia unit. Observation and interviews with family/whānau confirmed that residents can move freely around the dementia unit and that the accommodation meets their needs. There are grassed and paved areas accessible from both the rest home and dementia unit. The external areas in both areas have outdoor seating and shade and can be accessed freely by residents and their visitors.</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 hygiene requirements.</p>	FA	<p>There are sufficient accessible toilets and showering facilities of appropriate design to meet resident needs located in each area of the facility. Residents have access to shared toilet and bathroom facilities. There are no rooms with ensembles.</p> <p>Toilets have a system to indicate vacancy and have disability access. There are two visitors' toilets, one of which is close to the dementia unit. Some shower and toilet facilities have recently been upgraded and all have call bells; sufficient room; approved handrails; and other equipment to facilitate ease of mobility and independence.</p> <p>Residents were observed being supported to access communal showers in a manner that was respectful and preserved the resident's dignity.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with</p>	FA	<p>There are two double rooms and all other bedrooms are single rooms. All current residents have their own room, and each is of sufficient size to allow residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. Interviews with residents and family/whānau,</p>

<p>adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>and observation, confirmed that there is enough space to accommodate: personal items; furniture; equipment and staff as required.</p> <p>Residents and their families can personalise the residents' room. Furniture in residents' rooms was observed to include residents' own personal pieces and memorabilia; is appropriate to the setting and is arranged in a manner that enables residents to mobilise freely.</p> <p>There are designated areas to store equipment such as wheel chairs, walking frames, and hoists.</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>There is a dining room and adjoining lounge in the dementia wing and one in the rest home wing. All internal communal areas have seating and external views. Areas can be easily accessed by residents, family/whānau and staff. There are areas that are available for residents to access with their visitors for privacy if they wish. Observation and interviews with residents and family/whānau confirmed that residents can move freely around the facility and that the accommodation meets residents' needs.</p> <p>There are areas for storing activities equipment and resources. In each wing the lounge areas were observed to be used for activities.</p> <p>Residents were observed to have their meals with other residents in the communal dining rooms.</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 setting in which the service is being provided.</p>	<p>FA</p>	<p>The facility has two household staff members on morning shift, who provide laundry and cleaning services seven days a week. Interview and observation confirmed that they work together and share cleaning and laundry duties for the facility. One undertakes laundering of dirty clothes and cleaning of dirty areas such as toilets. The other undertakes cleaning in other areas such as resident rooms and is responsible for drying and folding of clean linen.</p> <p>Facility laundry, including residents' personal clothing, is completed onsite. Colour coded, covered laundry trolleys and bags were observed to be used for transport. Household staff interviewed confirmed knowledge of their role including management of any infectious linen. There is clear delineation and observation of clean and dirty areas in the laundry. Staff, resident and family/whānau interviews and complaint forms confirmed that there were no significant issues relating to missing residents clothing and that the laundry services provided meet residents' requirements.</p> <p>Cleaning duties and procedures are documented to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. The cleaners store chemicals on a trolley when cleaning and are aware of the need to always keep the trolley with them at all times. Staff receive training in correct use of cleaning products.</p>

		<p>Hand washing facilities are available throughout the facility, with alcohol gels in various locations.</p> <p>The effectiveness of cleaning and laundry processes are monitored through the internal audit process with no significant problems identified. Resident and family/whānau interviews, resident surveys and observation noted the facility to be clean and tidy.</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>	FA	<p>An approved fire evacuation plan was sighted. Fire drills are conducted at least six-monthly. There is a sprinkler system installed throughout the facility and exit signage displayed. Training records confirmed that staff have undertaken fire training. A RN is the nominated fire warden on each shift.</p> <p>Records and interviews evidenced that sufficient staff have current first aid certificates. This includes for example all RNs, and a number of other staff including the diversional therapist and maintenance person who drives the van. There are at least two staff members on each shift who have a current first aid certificate.</p> <p>The facility has sufficient supplies to sustain staff and residents in an emergency situation. Alternative energy and utility sources are available in the event of the main supplies failing. These include: a barbeque; torches; and enough food; water; and continence supplies. Emergency supplies are checked monthly. There is emergency lighting in corridors, that is tested monthly by an external contractor. The service's emergency plan includes considerations of all levels of resident need.</p> <p>Call bells are available to summon assistance in all residents' rooms and bathrooms. Call bells are checked monthly by the maintenance person. Observation and family/whānau interviews confirmed that call bells are answered promptly.</p> <p>Security systems are in place to ensure the protection and safety of residents, visitors and staff. These include visitors signing in and out of the building and the facility being locked in the evenings with restricted entry, through ringing a call bell at the front entrance afterhours and security lighting.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas accessed by residents, have safe ventilation and at least one external window, providing natural light. The facility is heated by heat pumps, gas heaters and the dementia unit has underfloor heating. The environment in all areas was noted to be maintained at a satisfactory temperature for residents. Systems are in place to obtain feedback on the comfort and temperature of the environment. The temperature of facility communal areas is monitored and reported. Observation and interviews with residents and families confirmed that the environment is maintained at a comfortable temperature and there are no issues identified with the temperature of the facility.</p>

		The facility has designated external smoking areas, one for the dual-purpose wings and one for the dementia unit. At the time of the audit there was one resident in each area who smokes.
<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>	FA	<p>Ultimate Care Aroha provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an infection prevention and control programme. The CSM is the infection control nurse (ICN) and has access to external specialist advice from the DHB infection control specialists, and microbiologists when required. A documented role description for the ICN, including role and responsibilities, is in place.</p> <p>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, clinical records and short-term care plans. 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>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICN is responsible for implementing the infection control programme.</p> <p>The ICN articulated that there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the facility's meetings. The ICN has access to all relevant resident data to undertake surveillance, internal audits, and investigations. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and</p>	FA	<p>The service provider has documented policies and procedures in place that reflect current best practice relating to infection prevention and control.</p> <p>Staff were observed to be complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.</p>

appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>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 is maintained. Staff interviewed confirmed their understanding of how to implement infection prevention and control activities into their practice.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, analysed, monitored and reviewed. Trends are identified, and action plans are implemented. Staff interviewed reported they are informed of infection rates at monthly staff meetings and through access to reports. The GP is informed within the required timeframe when a resident has an infection and appropriate antibiotics are prescribed. There is an antimicrobial policy.</p> <p>The UCG executive team completes benchmarking for infection prevention and control within their organisation. The ICN interviewed confirmed there had been no outbreaks within the facility since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The definition of restraint and enabler use are congruent with the definitions in the restraint minimisation and safe practice standards. The approval process for an enabler use is activated when a resident voluntarily requests an enabler. Interviews confirmed that enablers are used to assist residents to maintain independence and/or safety.</p> <p>The service had one resident using a bedrail as an enabler and no residents using restraints. The restraint and enabler register is maintained.</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 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA</p> <p>Moderate</p>	<p>The RNs and the clinical services manager complete assessments on admission. Care plans are comprehensive, and interventions support the identified goals.</p> <p>Two residents were reviewed for the management of falls. For one of the residents, a recent fall that resulted in injury, did not have any neurological observations completed. Another resident, who’s records were reviewed in relation to the management of falls showed that all their falls had neurological observations initiated, however the timeframes for completing the neurological observations did not meet good practice standards. The timeframes for completing neurological observations varied between none and stretching over nine hours.</p>	<p>Timeframes for neurological observations after unobserved falls, do not meet good practice.</p>	<p>Ensure timeframes for neurological observations to meet accepted good practice standards.</p> <p>60 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.