The Ultimate Care Group Limited - Ultimate Care Bishop Selwyn

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 Bishop Selwyn
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 September 2020 End date: 2 September 2020

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 64

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 Bishop Selwyn provides rest home and hospital level care for up to 78 residents. Occupancy on the first day of audit was 64. There have been no alterations to the facility since the last audit.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, contracted allied health providers and a general practitioner.

Areas identified as requiring improvement relate to governance, quality and management systems, assessments, medication management and facility specifications.

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.

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights on admission. Services are provided that support personal privacy, independence, individuality and dignity.

All residents including those who identified as Māori have their needs met in a manner that respects their cultural values and beliefs.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Informed consent is practised, and written consent is gained when required.

Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse and neglect.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

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

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

An experienced facility manager oversees the facility with the support of a regional manager. A qualified clinical manager supervises the clinical services. The clinical manger is a registered nurse with a current practising certificate.

The facility adheres to the Ultimate Care Group quality and risk management system which includes collection and analysis of quality improvement data, identifies trends and risk mitigation. All data collection and reporting follow a schedule. Meeting minutes are held to discuss key clinical performance indicators, quality and risk issues, resident satisfaction.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

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

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

Long-term care plans are developed and implemented within the required timeframes. Care plans are individualised and based on an integrated range of clinical information. Residents' needs, goals and outcomes are identified. Evaluations of care plans are completed at least six-monthly. Residents and their relatives are involved in the care planning process and notified regarding any changes in a resident's health status.

Short-term care plans are in place to manage short-term issues or problems as they arise. Handovers between shifts guide continuity of care and teamwork is encouraged.

An electronic medication management system in place. Medications are administered by registered nurses and care givers who have completed current medication competency requirements.

The activity programme is managed by two diversional therapists. The programme provides residents with a variety of individual and group activities and maintains their links with the community. Family are able to participate in the activities programme.

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

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 low risk.

There is a current building warrant of fitness. A reactive and preventative maintenance programme is implemented. External areas are accessible, safe and provide shade and seating.

Residents bedrooms are of an appropriate size for the safe use and manoeuvring of mobility aids if required and allow for care to be provided. Lounges, dining rooms and sitting alcoves are available for residents and their visitors. Communal and individual spaces are maintained at a comfortable temperature.

A call bell system is available to allow residents to access help when needed. Security systems are in place and staff are trained in emergency procedures, use of emergency equipment and supplies, and attend regular fire drills.

Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken on-site and off-site and evaluated for effectiveness. Cleaning of the facility is conducted by household staff and monitored by the internal audit programme.

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.

Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the restraint coordinator who is a registered nurse. On the day of the on-site audit no restraints or enablers were in use. Restraint is only used as a last resort when all other options have been explored. Enablers are voluntary.

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, trended and benchmarked. Monthly surveillance data is reported to staff and to the Ultimate Care National Office. There has been one outbreak since the previous audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	40	0	4	1	0	0
Criteria	0	88	0	4	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Ultimate Care Bishop Selwyn (UC Bishop Selwyn) has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. As verified in training records, training on the Code is included is provided for staff as part of the orientation process and in ongoing training.
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	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed demonstrated that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents who are unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the advocacy service. Posters and brochures related to the advocacy service were also displayed and available in the facility. Family members and residents interviews confirmed that they were aware of the advocacy service, how to access this and their right to have support persons.
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 are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has restricted visiting hours directly related to Covid-19. Families are welcome if an appointment is made. Normally there is unrestricted visiting hours and UC Bishop Selwyn encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed stated that they knew how to make a complaint. The complaints register reviewed showed that two complaints have been received over the past year and that actions taken, through to an agreed resolution, were documented and completed within required timeframes. Action plans show any required follow up and improvements have been made where possible. The facility manager (FM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. The FM advised that there have been no complaints with external agencies since the last audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	On admission residents are given a copy of the Code and the Nationwide Health and Disability Advocacy Service (advocacy service) as part of the admission information provided and discussion with staff. The Code is displayed throughout the facility together along with information on advocacy services, how to make a complaint and feedback forms. Residents and family interviewed stated they would feel comfortable raising issues with staff and management.

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	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Residents are encouraged to maintain their independence by involvement with community activities and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.
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.	FA	There is a current Māori health plan that guides staff in meeting the needs of the residents who identify as Māori. Any additional cultural support, if required would be accessed locally. This was confirmed during an interview with the facility and clinical managers. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs. Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs.
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	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. Staff are guided by policies and procedures. Staff interviews demonstrate a clear understanding

		of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Ultimate Care Bishop Selwyn implements Ultimate Care Group Limited (UCG) policies and procedures which are based on good practice, current legislation and relevant guidelines. The service encourages and promotes good practice through; evidence based policies, input from external specialist services and allied health professionals such as district nurse wound care specialist and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Included in the new initiative by a local hardware company to supply supplies such as nails, wood and tools to enable the facility to develop a men's group for residents.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff interviews confirmed that they understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Residents and families are invited to take part in monthly resident's meetings as evidenced in meeting minutes. The resident's need for an interpreter is assessed on admission to the facility. Access to interpreters is organised through families or the district health board (DHB).
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA Low	Ultimate Care Bishop Selwyn is part of UCG with the board, board committees, and executive team providing direction and support to the service. The organisation has vision, mission and value's in place which are resident centred. The organisation's values were displayed in the foyer of the facility. An area identified for improvement relates to the FM annual business plan which outlines annual objectives for the quality of service delivery and performance at a local level. The FM reports monthly to a regional manager on key performance indicators. The service is managed by a FM who holds relevant qualifications and has been in the role since

		November 2019. The FM has a nursing background and has performed similar roles for other providers for the past 30 years. The clinical manager (CM) has worked in the facility for seven years and has held this position since November 2019. Both managers maintain their knowledge of the sector through representation and participation in aged care forums and seminars. The service provides hospital and rest home level care for up to 78 residents. The facility is certified for 78 dual purpose beds. Five of the dual-purpose beds were used as occupation right agreements (ORAs). At the time of the audit, there were a total of 64 residents in the facility: 37 receiving rest home level care, and 27 receiving hospital level care. Included in these numbers was one young person under a chronic health conditions contract assessed at hospital level of care and five residents with ORAs, four assessed at rest home level and one at hospital level. The facility has contracts with the DHB for age-related care, chronic health conditions, support care, end of life and support care medical illness.
Standard 1.2.2: Service 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.	FA	In the event of a short-term absence of the FM, the FM with support from the regional manager is responsible for the day-to-day operations of the facility. The CM is supported by senior registered nurses (RNs) who can help cover leave if necessary. The regional manager assists the FM as needed and was observed doing do during the audit. The FM reported the current arrangements work well.
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	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes: management of incidents and complaints; audit activities; a regular patient satisfaction survey; monitoring of outcomes and clinical incidents including infections. The system promotes collaboration between the senior management team, regional managers, CMs staff and residents. Thereby ensuring monitoring and implementation of continuous quality improvement within the organisation. Ultimate Care Bishop Selwyn uses a range of audit and survey data to benchmark its service against other facilities in the network, improve quality and mitigate risk. The facility adheres to UCG wide policies and procedures that are current. A document control policy is in place. A range of quality activities are documented. This includes the collection of quality data including the results of internal audits, accidents/incidents reports, health and safety reporting, infection

		control data, restraint, complaints and resident satisfaction surveys. Clinical indicators are forwarded to the regional manager and are used in the UCG benchmarking programme. Quality related information is shared with all staff as confirmed in meeting minutes sampled. Monthly residents' meeting minutes sighted also confirm that resident feedback is sought and where appropriate corrective actions are developed and implemented. An area identified for improvement relates to meeting minutes and developed corrective action plans following the completion of internal audits. The FM is the health and safety officer with assistance from the maintenance manager, both have received recent training in health and safety. A current hazard register identifies health and safety risks and risk ratings associated with different areas of the environment, service delivery and human resource management. The health and safety committee meets monthly to review health and safety findings and actions plans are developed.
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.	FA	Interview with the FM described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health. Staff interviewed are aware of the organisation's policies and processes regarding the reporting, the notification and the management of adverse events. Staff document adverse and near miss events on an accident/incident form. A sample of accident/incident forms reviewed showed these were fully completed, including notifying the residents family/EPOA, GP and emergency services when necessary. Staff interviewed stated that they commenced the process on the accident/incident form and the RN then enters the data into the electronic data base. Accidents/incidents were investigated, action plans developed and actions followed-up in a timely manner. The CM is responsible for reviewing clinical accidents/incidents and for developing corrective action plans to mitigate future risks. Event data is collated, analysed and reported to at staff meetings. A national level report is produced monthly and reported through at a local level at staff meetings.
Standard 1.2.7: Human Resource Management Human resource management	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and annual practising certificates (APCs), where required. A sample of

processes are conducted in accordance with good employment practice and meet the requirements of legislation.		staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed demonstrate documentation of completed orientation. Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There are six of the eight RNs who are trained and maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, 7 days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a three-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. The RN on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital. The ORAs are incorporated into the existing dual purpose bed configuration.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Resident progress notes are completed every shift, detailing resident response to service provision and progress towards identified goals. Records were legible with the name and designation of the person making the entry identifiable. Residents files reviewed included relevant information on the residents' care and support details that could be accessed in a timely manner. There are policies and procedures in place to ensure privacy and confidentiality. Staff interviews described the procedures for maintaining confidentiality of resident's records. No personal or private resident information was on public display during the audit.

		Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessments entered into the electronic database.
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 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 a comprehensive information pack provided to all residents and their families prior to admission. Review of residents' files confirmed entry to service processes, ensuring compliance with entry criteria. Interviews with residents and family and review of records confirmed the admission process was completed by staff in a timely manner. Residents and family members interviewed stated that they had received the information pack and sufficient information prior to and on entry to the service.
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	A current medication management policy identifies all aspects of medicine management in line with the current legislation and guidelines. A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices in line with legislation, protocols and guidelines were observed. The required three-monthly reviews by the GP were recorded electronically. Resident allergies and sensitivities are documented on the electronic medication chart. 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. Review of the medication fridge evidenced that the service does not store or hold vaccines and

		interviews with the RN confirmed this. The medication refrigerator temperatures are monitored weekly. 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 demonstrated knowledge and clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures. This was confirmed at interview. The RNs oversee the use of all pro re nata (PRN) medicines and documentation, regarding effectiveness, on the electronic medication record and in the progress notes (sighted). Current medication competencies were evident in staff files. There was one resident self-administering medication during the on-site audit. A process is in place to ensure ongoing competency of the residents and self-medication is authorised by the GP. However, verification of self administration of medication by the RN did not occur. Safe storage for medication was not provided.
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 two 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. Not all staff working in the kitchen have food hygiene certificates, this is due to difficulty accessing training for recently employed staff during the Covid-19 lockdown. Training for these two staff members has been planned. Food temperatures are monitored appropriately and recorded. 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. 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 managed by the organisation, where appropriate.	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 GP 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.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The initial nursing assessment and the initial care plan are completed within 24 hours of admission. The initial care plan guides care for the first three weeks. 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 and specialists. The physiotherapist assesses all residents on admission for mobility, manual handling and safe transfer requirements. Policies and protocols are in place to ensure continuity of service delivery. InterRAI assessments are carried out six-monthly. Interviews with residents and families confirmed their involvement in the assessments, care planning, review, treatment, and evaluation of care. There is a policy in place for wound care; however, wound assessments are not consistently documented (refer 1.3.6.1).
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Long-term care plans are developed with resident and family/whānau involvement. All residents' files sampled had an individualised long-term care plan. Long-term care plans describe interventions in sufficient detail to meet residents' assessed needs. Short-term care plans are developed for the management of acute problems. Resident files showed service integration with clinical records, activities documentation, and medical and allied health professionals' reports and letters. Interviews with residents confirmed that they have input into their care planning and review, and that the care provided meets their

		needs. Review of the resident's clinical record and interview showed that the resident under the young people with disabilities (YPD) (chronic health) contact were involved in care planning. Their plan included activities to ensure their wellbeing, community participation and interventions to meet their physical, health and wellbeing needs.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	Long-term care plans are completed by the RN and based on the assessed needs, desired outcomes and goals of residents. Interventions are reviewed within required timeframes. The GP documentation and records reviewed were current. Interviews with residents and families confirmed that care and treatment met residents' needs. Staff interviews confirmed they are familiar with the needs of all residents in the facility. Family communication is recorded in the residents' files. The nursing progress notes and observations are recorded and maintained. Adequate dressing supplies were sighted. However, wound management is not consistently carried out in accordance with UCG policy and best practice. Continence products are available and resident files include interventions to promote urinary and faecal continence and to manage incontinence.
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.	FA	The residents' activities programme is implemented in the rest home and hospital by two diversional therapists. They are assisted by an activities coordinator. Activities for residents are provided 5 days a week, Monday to Friday 9 am to 5 pm. On Saturday and Sunday a range of activities are made available for residents, staff and family to access. The activities programme is displayed on the resident noticeboards. The activities programme provides variety in the content and includes a range of activities which incorporate education, leisure, cultural, spiritual and community events for example church services, quizzes, happy hour, baking and daily exercises. Van outings into the community are arranged weekly. The resident under the YPD contract is included in the activity programme. Interview confirmed that they were satisfied with activities that were provided. Additional activities are facilitated which include assistance with accessing knitting and crocheting supplies, and trips to the garden centre to buy plants for their personal garden space. The residents' activities assessments are completed within three weeks of the residents' admission to the facility in conjunction with the admitting RN. Information on the 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.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it 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. However, evaluation of wound care was not carried out consistently (refer 1.3.6.1). Residents and families interviewed confirmed involvement in the evaluation process and any resulting changes. Contact with family was verified in the resident's records and documented in the individual resident files reviewed.
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 made 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. Communication records reviewed in the residents' files confirmed family/whānau are kept informed of the referral process.
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	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and provide relevant training for staff. Safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this.
Standard 1.4.2: Facility Specifications	FA	A current building warrant of fitness is publicly displayed.

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of biomedical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe, and independence is promoted. This includes the removal of equipment such as linen trolleys and cleaning equipment. External areas are safely maintained and are appropriate to the resident groups and setting. Interviews with residents confirmed they know the processes they should follow if any repairs or maintenance is required, that any requests are appropriately actioned and that they are happy with the environment.
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	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. All rooms have a private toilet and handbasin. Communal shower rooms are used in the hospital wing of the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. Hot water temperatures are monitored monthly. When hot water temperatures are above the recommended safe temperature action is taken and rechecking of the temperature occurs to ensure it is maintained at a safe temperature.
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	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe,	FA	Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.

adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		
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.	FA	Laundry is undertaken on site in a dedicated laundry and white linen is processed off site by a contracted provider. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. There is a small designated cleaning team who have received appropriate training in the use of chemicals for cleaning purposes. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Sluice rooms are available for the disposal of soiled water/waste. Handwashing facilities are available throughout the facility. Cleaning and laundry processes are monitored through the internal audit programme.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	PA Low	Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service in 2003. A trial evacuation takes place with a copy sent to the New Zealand Fire Service, the most recent being in July 2020. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas barbeques were sighted and meet the requirements of 78 residents. First aids kits located in the civil defence emergency boxes has been identified as an area requiring improvement. Water storage tanks are located around the complex. Emergency lighting is regularly tested. Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time.

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	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and open onto the outside garden or small patio areas. Heating is provided by a variety of ways including underfloor heating or ceiling heaters in residents' rooms, night store heaters, and heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a 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 Bishop Selwyn provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an infection prevention and control programme. The CM is the infection control nurse (ICN) and has access to external specialist advice from the DHB ICN. A documented job description for the ICN, including role and responsibilities, is in place. 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, progress notes and clinical records. There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff, residents, and visitors to use.
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. There is an infection control committee which is made up of staff members from each work area. The ICN has attended training at the DHB and is planning to complete training for the role through the Ministry of Health (MOH) online training course. The DHB ICN visits the facility to provide education and advice. The ICN stated that there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the facility's quality 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 and control of infection reflect current accepted good practice	FA	Ultimate Care Group Limited has documented policies and procedures in place that reflect current best practice relating to infection prevention and control. Staff observed were complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions. They were able to locate

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.		policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	All staff attend infection prevention and control training. Staff education on infection prevention and control is provided by the ICN at orientation and monthly at the quality meetings and as part of the UCG staff training programme. Records of attendance are maintained. Staff interviewed confirmed that education on infection prevention and control is provided. Education with residents, when possible, is generally on a one-to-one basis and includes reminders about handwashing and remaining in their room if they are unwell. Staff provide education for residents where appropriate about Covid-19 as updates occur. There is information regarding infection prevention and Covid-19 displayed on the noticeboards. Staff receive notifications and updates about infection control via noticeboards, meetings and at handovers.
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	Ultimate Care Group Limited surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal audits are completed. Short-term care plans are developed to guide care and evaluate treatment for all residents who have an infection. New infections and any required management plans are discussed at handover to ensure early intervention occurs. Families are updated by phone, email or text if required. Surveillance data is collected and collated monthly by the CM and forwarded to the UCG national office for benchmarking using an electronic system. Information following monthly infection data collection and benchmarking is provided to staff through quality and staff meetings and on the staff noticeboard. Interview with the ICN confirmed there has been one outbreak (influenza May 2019) since the previous audit. Evidence was sighted that the outbreak was managed in accordance with requirements. Covid-19 information is available to all visitors to the facility. Ultimate Care Group Limited, information including MOH information was available on site. There are adequate infection prevention and control resources 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 CM, who provides support and oversight for enabler and restraint management in the facility. The CM is conversant with restraint policies and procedures. On the day of the audit there were no residents using restraints or enablers. Restraint is used as a last resort when all alternatives have been explored. Enabler use is voluntary. This was evident from interviews with staff who are actively involved in the ongoing process of restraint minimisation. A review of restraint and enabler use is completed and discussed at all quality and clinical 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 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	PA Low	Ultimate Care Group Limited provides each facility with a template to outline the facilities annual business plan. The plan includes an action plan which outlines an annual quality plan for the facility. On discussion with the FM they were unaware of the existence of a facility specific business plan. The regional manager provided the UC Bishop Selwyn business plan; however, this was dated 2019.	The UC Bishop Selwyn annual business plan had not been reviewed for 2020.	Ensure a current business plan is available for UC Bishop Selwyn. 180 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and	PA Low	Meeting minutes and internal audits are completed as per the annual planner. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the head of department meeting, quality and staff meetings. The documentation reviewed indicated corrective actions to be undertaken to address relevant issues are developed, however, the cycle to	Meeting minutes and internal audits corrective action plans, identifying requirements for improvements, do not consistently include recorded evidence of the person responsible for implementing the corrective action, the	Ensure all meeting minutes and corrective action plans consistently evidence the person responsible for implementing the corrective action plan,

implemented.		ensure implementation of quality improvement was not documented.	required timeframe for implementation and date the action is closed.	the required timeframes and the date the action is closed. 180 days
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Moderate	Competency assessment for the resident self-medicating was in place and was signed by the CM and the GP. However, there was no record kept of the type, amount or frequency of medication self-administered. There was no secure storage provided in the resident's room for the self-administered medication. The medication policy provides guidance on the safe storage of medications.	Self administration of medication is not carried out in accordance with UCG policy and best practice.	Ensure that self administration of medications is carried out in accordance with UCG policy and best practice. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	There is a wound care policy in place. However, wound assessments were not in place for seven out of sixteen wounds reviewed and wound evaluation (measurements and/or photos) were not recorded for six out of sixteen wounds reviewed. Registered nurses interviewed could describe access to the DHB wound nurse as required.	Wound assessment and evaluation is not carried out consistently in accordance with UCG policy and best practice.	Ensure that wound management is carried out in accordance with UCG policy and best practice. 90 days
Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire	PA Low	The facility has two civil defence kits that holds items such as lights, batteries and emergency blankets. The kits are checked regularly by the maintenance personal. Although there is not list of contents. A separate first aid box is kept in the kit, that holds items such as single use sterile dressings, dressing solutions and medication. However, some items had expired. Each first aid box held a different assortment of	First aid boxes do not have a list of designated content items and a number of single use items I had expired.	Ensure all first aid boxes have a list of designated content items and all single use items are within date. 60 days

safety and emergency procedures.		items.		

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.