

The Ultimate Care Group Limited - Ultimate Care Manurewa

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	The Ultimate Care Group Limited
Premises audited:	Ultimate Care Manurewa
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 July 2021 End date: 28 July 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	42

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ultimate Care Manurewa can provide rest home and hospital level care for up to 51 residents. At the time of the audit 47 rooms were available for use. There were 42 residents at the facility on the first day of the audit.

This surveillance audit was conducted against a subset of the Health and Disability Services Standards and the facility's contracts 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, residents, management, staff, and a nurse practitioner.

An area requiring improvement at the last certification audit relating to observations following an unwitnessed fall is now closed. The area relating to required timeframes for care planning and admission agreements remains open and is partially closed.

Additional areas identified as requiring improvement at this audit relate to quality improvements; medication management; essential emergency systems; and surveillance.

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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Staff communicate with residents and family members following incidents and this is recorded in the resident's file. Interviews with residents, family/whānau and the nurse practitioner confirmed that the environment is conducive to communication 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 Commissioner's 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 have been no complaints to external agencies 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.		Some standards applicable to this service partially attained and of low risk.
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The Ultimate Care Group Limited is the governing body responsible for the services provided at Ultimate Care Manurewa. The strategic direction, values, and goals of the organisation are documented and communicated to all concerned.

The facility has implemented the Ultimate Care Group Limited's quality and risk management system that supports the provision of clinical care and quality improvement meetings. There is regular reporting on various clinical indicators, quality and risk issues, and monitoring and discussion of identified trends.

There is an implemented incident and accident management system to record and report adverse, and unplanned or untoward events.

Ultimate Care Manurewa is managed by an appropriately qualified facility manager who is supported by the regional operations manager. The facility manager is also supported by a newly appointed clinical services manager who is responsible for clinical management and oversight of service delivery. Both the facility manager and clinical services manager are registered nurses with current practicing certificates.

The Ultimate Care Group Limited's human resource policies and procedures guide practice and human resource processes are followed. Newly recruited staff undertake orientation appropriate to their role and ongoing training is provided. Individual performance reviews take place annually.

There is a documented staff allocation process in place to ensure staffing with appropriately skilled, educated and qualified staff. Staffing rosters meet contract requirements.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The provision of services is delivered by staff with appropriate knowledge and skills. All residents have care plans specific to the individual's needs. Evaluation of the care and interventions is on-going and meets best practice guidelines.

The activity programme provides residents with individual and group activities and maintains a connection with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service caters for the resident's needs, with individual requirements being met. There is a current food plan. Residents were satisfied with the meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The facility has a current building warrant of fitness. There have been no structural alterations since the last audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. One restraint and two enablers were in use at the time of audit. Use of enablers is voluntary and implemented at the request of the resident. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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An infection prevention and control surveillance infection programme is undertaken, and results are reported through all levels of the organisation.

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	12	0	1	4	0	0
Criteria	0	39	0	1	4	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>There is a current complaints policy and procedure outlining the complaints process. The policy is in line with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code) and includes the expected timeframes for responding to a complaint. The complaint process is made available as part of the information pack and explained to the resident and family/whānau on admission. Complaint forms are also available at the entrance to the facility and in a brochure holder in each resident's room (sighted).</p> <p>The FM is responsible for managing complaints. There have been 17 complaints since the last audit. The sample reviewed demonstrated that both written and verbal complaints are responded to. Each complaint was acknowledged in writing within the required timeframe, and the outcome of the complaint investigation was communicated to the complainant in a timely manner. An up-to-date complaints' register (sighted) is in place, that clearly details the sequence of events relating to each complaint, alongside relevant evidence and complaint documentation.</p> <p>Residents and family/whānau interviewed reported that they are aware of the process to make a complaint and felt comfortable raising any issues directly with management and staff. They stated that any issues raised were responded to, to their satisfaction. Residents and family/whānau stated they were aware of advocacy services, that could be accessed in relation to the complaints process.</p> <p>Management interview stated that there had been no complaints to external agencies since the last audit.</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>There is a policy in place to ensure that adverse events, where a resident has suffered unintended harm while receiving care, are documented, investigated and communicated in an open disclosure manner. Completed incident documentation and clinical files reviewed demonstrated that residents and family/whānau were informed when a resident had an accident/incident; a change in health; or a change in needs. This was confirmed in family/whānau and residents' interviews.</p> <p>Staff, residents and family/whānau interviews by the consumer auditors also confirmed that family/whānau are included, where appropriate, in resident care planning meetings. Resident meeting minutes evidenced that a range of subjects and issues are discussed, including but not limited to: activities; food service; and staffing changes. Resident interviews and meeting minutes evidenced that meetings provide residents with an opportunity to provide feedback or raise issues (refer to 1.2.3.5). The facility manager (FM) stated that copies of the meeting minutes are made available to residents following each meeting. Residents and family/whānau are provided with a facility newsletter every three months (sighted).</p> <p>There is a policy to ensure that information is supplied in a way that is appropriate for the resident and/or their family. Interview with the FM stated that residents who do not use English as their first language are offered interpreting services, that can be sourced through the district health board (DHB) if required. The FM interview confirmed that there were no residents at the time of the audit, who required interpreter services. Staff interviews described how communication was managed and facilitated for one young person with a disability (YPD), who was unable to communicate verbally.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The facility is part of the Ultimate Care Group (UCG) with the national support office providing support to the facility.</p> <p>The organisation's business plan provides the strategic direction for the facility, alongside specific values and focus areas that reflect a person/family/whānau centred approach to resident care. The values are communicated to all concerned.</p> <p>The FM reported that the facility has regular contact with the regional manager and there is regular communication between the service and the support office, via the regional manager. The regional manager provided support during the on-site audit. There is ongoing electronic reporting to the national support office that demonstrates progress against identified indicators. The clinical services manager (CSM) provides a narrative reflection report against specific clinical indicators. Monthly reports to the regional manager and national office (sighted) evidenced reporting against a range of key areas focus for the facility such as, but not limited to: staffing; falls; medication errors and infections.</p> <p>The service is managed by a FM who has been in the role for 18 months and has 6 years' experience in aged</p>

		<p>care, including facility coordination. The FM has completed relevant training and education related to aged-related residential care (ARRC) and management. Responsibilities and accountabilities of the FM role are defined in a job description and individual employment agreement. The CSM has worked in the facility for 18 months and commenced in the CSM role the day prior to the audit. The CSM has ARRC experience in another facility. Both the FM and CSM are registered nurses (RNs) with current practicing certificates.</p> <p>The facility is certified to provide rest home and hospital care services for up to 51 residents. Of these beds, two are not available due to refurbishment in progress and two are utilised for storage. There were 42 beds occupied at the time of the audit. This included 34 residents who had been assessed as requiring hospital level care and 8 residents assessed as requiring rest home level care. The hospital numbers included: two residents who were under the primary options for acute care (POAC) contract; three residents under the age of 65 years under the residential non-aged care consolidated outcomes (YPD) contract; one YPD (physical) and one YPD (intellectual) under the residential respite services agreement.</p> <p>The facility has contracts with the DHB for the provision of ARRC rest home and hospital level care; POAC; long-term chronic conditions and respite care.</p> <p>The facility does not have occupational right agreements.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The documented and implemented UCG quality and risk management plan specific to Ultimate Care Manurewa is accessed by staff to guide service delivery, improve quality, monitor compliance and manage risk. The plan is reviewed annually.</p> <p>Documented policies and procedures align with the Health and Disability Services Standards and reflect accepted good practice guidelines. There is a centralised document control system to manage policies and procedures. The UCG management reviews all policies with input from relevant personnel. Staff have electronic access via the UCG intranet. New and revised policies are presented to staff at meetings, which was verified by staff interviewed. Alerts on the electronic log-on systems also inform staff of new policies and amendments.</p> <p>The quality and risk management plan supports continuous quality improvement through the implementation of quality and risk programmes such as a schedule of annual internal audits, training, meetings and reporting. Interviews with managers and documents reviewed confirmed that an annual internal audit programme is implemented. All aspects of quality improvement, risk management and clinical indicators are discussed at monthly meetings. Staff interviews, and meeting minutes confirmed that staff are kept informed of quality activities, and that quality data and corrective actions are developed, and discussed at staff meetings. However, closure of corrective actions was not consistently evidenced.</p> <p>Residents' meeting minutes demonstrated that residents' feedback received during meetings inform the development and implementation of quality improvement initiatives and changes to service. Interviews with residents and family/whānau confirmed that residents including YPD, are satisfied that they have input into</p>

		<p>quality improvements. Satisfaction surveys for residents and family/whānau are completed as part of the annual internal audit programme. Survey results reviewed evidenced satisfaction with the services provided. There was evidence that corrective actions were developed and implemented for opportunities for improvement arising from resident satisfaction surveys.</p> <p>Health and safety policies and procedures are documented along with a hazard management programme. Staff interviews stated that they were encouraged to report all hazards, accidents and incidents promptly and described an awareness of health and safety processes and their responsibilities. Review of completed incident forms established that hazards are addressed, and risks minimised. A current hazard register is available.</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>	FA	<p>The management team is aware of situations which are required to be reported to statutory authorities, including: unexpected deaths; police involvement; sentinel events; infectious disease outbreaks and changes in key management roles. Essential notifications are reported to the appropriate authority via the UCG support office. Notifications to HealthCERT under Section 31 were sighted for an unstageable pressure injury and the appointment of the FM and CSM. Two morning shifts (sighted) where there was no RN available were reported to the DHB. Interview with the FM advised that the DHB were satisfied that the presence of both the FM and CSM on these shifts provided sufficient temporary RN cover.</p> <p>Staff interviewed understood the adverse event reporting process and their obligation to document all untoward events. A review of documentation confirmed that staff document adverse, unplanned or untoward events on accident/incident forms which are signed off by the FM.</p> <p>Review of staff training records confirmed that staff receive orientation and ongoing education on accident/incident reporting processes.</p> <p>Accident/incident reports reviewed and residents and family/whānau interviewed evidenced that where appropriate, the resident's family/whānau and general practitioner (GP)/nurse practitioner (NP) had been notified of the incident. The events' records demonstrated that assessments and action plans had been documented for each event including neurological observations in response to unwitnessed falls. The previous improvement is now closed.</p> <p>Accident/incidents are graphed, trends analysed and fed back to staff at staff meetings.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes</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; police vetting; identification verification; a position specific job description; a signed employment agreement and where required</p>

<p>are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>a current work visa.</p> <p>Professional qualifications are validated, and current practitioners' certificates were evidenced for all staff and contractors who required them. There are systems in place to ensure that annual practising certificates remain current. New staff receive an orientation/induction programme that covers the essential components of the services provided. Care givers (CG) interviews stated that they are buddied with an experienced staff member until they are confident and competent on specific tasks.</p> <p>The organisation has a documented annual education and mandatory training module/schedule that includes topics relevant to all services, and to all levels of care provided. Four of six permanent RNs, including the CSM, have completed interRAI assessment training and competencies. All care staff complete annual competencies, for example: moving and handling; hoist use; and hand washing.</p> <p>Attendance records evidenced that staff receive ongoing education which is relevant to the services delivered. Interviews and training records reviewed confirmed that all staff, including RNs, undertake at least eight hours of relevant education and training hours per year.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The organisation's staffing and skill mix policy and documented formula provide guidance to ensure staffing levels within the facility; meet the needs of residents' and adhere to the minimum requirements of the DHB contract. Staffing levels are reviewed to accommodate anticipated workloads identified numbers of residents, and their acuity.</p> <p>There are 6 RNs and 21 CGs available to maintain the rosters for the provision of care. There is also a casual pool with RNs and one enrolled nurse (EN) available to supplement the rosters when needed. Interview with the FM identified that agency RNs are required at times. The FM and CSM work on morning duties on week days. There is at least one RN on all shifts, seven days per week. On two day shifts the RN shift has been covered by the CSM, supported by the FM. In addition, on each morning shift there is one senior CG in the rest home wing and four CGs for the hospital. Afternoon shifts have on one senior CG in the rest home wings and four CGs in the hospital. On night shifts there are two CGs for the whole facility. Rosters sighted reflected adequate staffing levels to meet current resident acuity and bed occupancy. Residents with higher needs are situated in rooms closer to the nurses' station.</p> <p>The FM and CSM share the on call after hours, seven days a week. Interview with the management team advised that UCG senior managers are available, via a designated telephone number for 24/7 support on clinical matters.</p> <p>Observation of service delivery confirmed that residents' needs were being met in a timely manner. Residents and family/whānau interviewed stated that staff were busy; however, residents' care needs were met. Staff stated that they were very busy but complete their scheduled tasks and resident cares each shift.</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 guidelines.</p>	<p>PA Moderate</p>	<p>The service uses an electronic medication management service. All prescribing, administration and dispensing records comply with legislative requirements. The service contracts a local pharmacy to dispense and supply all resident's medication. Medication is delivered in pre-packaged rolls.</p> <p>There is a dedicated medication trolley for each wing of the facility, which is stored in a locked staff only store room. There is also a locked medication cupboard that stores residents' as required medication, and the medication fridge.</p> <p>Administration of medication is performed by RNs and CGs who have completed medication competency assessments. This was confirmed by education programmes and education records sighted. During the audit a CG was observed to be undergoing an annual competency assessment. Staff interviewed confirmed they participate in annual competency updates. A medication competent CG was interviewed, and stated CGs are restricted to administering as required paracetamol, and administer oral and topical medications only.</p> <p>High risk medications are stored in pharmacy pre-packed packages and in a secure environment that meets regulations. Documentation pertaining to these medications meets requirements, and weekly check are completed. The pharmacy undertakes, and documents six-monthly stock takes.</p> <p>Medication self-administration is not used in this service. The YPD residents of this service have been assessed as not competent to manage their own medication.</p> <p>The medication room was temperature monitored, and although the medication fridge temperature was monitored daily the temperature range was not within an acceptable range.</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>A planned menu is in place, consisting of a summer and winter menu. It is rotated in four weekly cycles.</p> <p>A letter of approval of the menu by a registered dietitian was sighted, dated 19 May 2021. A comprehensive list of each resident's individual requirements is held in the kitchen. Visual information with regard to food texture standards is displayed.</p> <p>Residents interviewed confirmed that they were satisfied with their meals, and this was confirmed by relatives interviewed. Kitchen, pantry, fridge and freezers sighted were clean and organised, cleaning records and fridge and freezer records are kept on site. Baking ingredients are stored in appropriate containers. All perishable food was stored appropriately, and any previously prepared food was covered, dated and stored in the fridge. There is a designated food preparation and cleaning area. The cook has appropriate New Zealand Qualifications Authority (NZQA) qualifications. The kitchen hands and the cook participate in annual organisational training updates related to food safety and infection control principles. A food control plan is in place, expiring 27 June 2022.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Short and long-term care plan interventions were documented in the residents' files sampled, which were appropriate to meet the residents' desired outcomes. Interventions documented included nursing interventions and specific interventions recommended by a member/s of the multidisciplinary team, for example the GP and/or wound clinical nurse specialist. Interventions were documented to address the physical, emotional, cultural and spiritual components of the resident's care. Specific requirements for individual residents were documented and included interventions for an underweight resident and a resident with a low blood pressure.</p> <p>Clinical records sampled, and resident and family interviews confirmed that the interventions occurred and were documented.</p> <p>Wound care plans documented the dressing products to be used.</p> <p>Clinical supplies of wound products, continence supplies, including catheterisation supplies were sighted and adequate for the size of the service.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme operates Monday to Saturday inclusive. The programme is planned and coordinated by a diversional therapist (DT) in training. The DT was interviewed and discussed the activities available and offered to all residents, including, those residents that are under 65 years of age. The DT stated that liaison occurs between the DT and the RNs to ensure residents participate in activities to meet their individual interests and level of need. Registered nurses interviewed advised that activity care plans were a component of the long-term care plan, and reviewed at six-monthly intervals following interRAI assessments, this was verified in clinical records sampled.</p> <p>Exercise sessions are offered Monday to Saturday. Residents who prefer not to mix with other residents, or who are unable to attend the group activities are seen by the DT who offers one to one time daily. Young persons with disability residents take part in the facility programme; however, the DT meets with these residents individually to discuss and plan any specifically requested activities and actions these.</p> <p>During the audit the programme was observed in action, and residents were seen to be involved; for example, one resident was calling out the bingo numbers, while other residents played. Outings are planned which include for example sightseeing trips, shopping, and going to a café.</p> <p>Clinical records sampled evidenced documentation of the resident's involvement in the activities programme.</p> <p>Residents interviewed confirmed they participated in and enjoyed the activities programme.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Registered nurses update the residents' progress notes as per requirements which provides a daily and ongoing evaluation of the resident's response to short and long-term care plans. Clinical files sampled evidenced that interRAI assessments are completed six-monthly and used to evaluate the care plan, which modifications being made to the updated care plan as indicated by the CAPs, and resident and family input.</p> <p>Residents are seen three-monthly by the GP, and as required, when a change in health status is observed.</p> <p>Clinical files sampled evidenced that where appropriate, evaluation of care takes place in conjunction with other service providers, for example the GP for a resident who has had an infection, or the wound clinical nurse specialist when evaluating the response to treatment of a wound.</p> <p>Where the response is different to that expected, changes to the care plan are made, for example an antibiotic may be changed, or dressing products are changed. One clinical sample evidenced a referral to a specialist service because the response to treatment what not what was expected.</p> <p>Clinical files and family interviews verified that where the response to treatment is not having the desired effect, family are notified.</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. There have been no alterations to the facility since the pervious audit.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Moderate</p>	<p>The facility has a current emergency and evacuation plan. Emergency planning includes consideration of all residents' needs and levels of mobility. Staff files and training records demonstrated that orientation and mandatory training includes emergency and disaster procedures as well as fire safety. Interviews with staff and review of documentation confirmed that fire drills are conducted at least six-monthly. There is appropriate firefighting equipment and signage available. However, egress via exit doors is obstructed.</p> <p>All RNs and four CGs have current first aid certificates, to ensure that there is at least one staff member on each shift with a current first aid certificate.</p> <p>The facility has enough supplies to sustain staff and residents in an emergency. Alternative energy and utility sources are available in the event of the main supplies failing.</p>

		<p>Call bells are available to summon assistance in all resident rooms and bathrooms. Call bells are checked monthly. 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, alarmed exit doors and restricted entry after hours.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>PA Moderate</p>	<p>The surveillance programme is suitable for the size and type of the service. Reports are generated monthly on the organisation's software and presented at staff meetings for discussion and used for education purposes as required.</p> <p>Short-term care plans are used to implement appropriate and consistent treatment for all infections. Staff interviewed and education records, confirmed staff are given annual updates on infection prevention and control principles. Adequate resources were sighted during the audit to ensure that the service would manage any outbreak of infection. There have been no outbreaks of infection since the previous audit.</p> <p>The surveillance reports are reported to the organisation's management monthly; however, these are not consistently acted upon.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy and procedures reflect the standard, providing definitions and guidance on the use of restraint and enablers. A RN is the restraint coordinator and holds a position description for the role. The restraint coordinator was interviewed and discussed the role and responsibilities. The restraint coordinator demonstrated knowledge of the indications for, monitoring and review of processes, and of the residents using restraint and/or enablers in the service.</p> <p>On the day of audit, one resident was using a restraint and two residents were using enablers. The enablers in use were implemented at the request of the resident, and signed consents relating to their use were sighted.</p> <p>The restraint in use during the audit was the least restrictive option and contributed toward maintaining the resident's safety. This was evident on review of the restraint committee minutes, review of the resident's file and from interview with staff.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	PA Low	A range of meetings are held to keep staff informed of operational and quality activities. Corrective actions are discussed, developed, and documented. Some meeting minutes such as health and safety and restraint show that corrective actions demonstrated closure and sign off. However, this is not consistently evident in all other facility meeting minutes.	Action points arising from meeting minutes do not consistently evidence closure and sign off.	<p>Ensure corrective actions arising from meeting minutes record closure and sign off.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage,</p>	PA Moderate	The medication fridge temperature is monitored and recorded daily. Records sighted over the past two months recorded a temperature range of 9 -11 degrees Celsius.	Medication fridge temperature recordings are not	Ensure medication fridge temperatures remain within

disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.			consistently within the recommended range.	the recommended range. 30 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>	PA Moderate	Clinical files sampled evidenced care plans that reflected the interRAI CAP report. Short-term care plans are implemented in response to an acute health care need. Care plans are evaluated six-monthly; however, not all initial interRAI assessments or care-plans were developed within the required timeframe.	Not all interRAI assessments or initial long-term care plans are completed within required timeframes.	Ensure all interRAI assessments and initial care-plans are completed within required timeframes. 90 days
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	PA Moderate	The facility has an approved fire evacuation plan in place and emergency exit signage is clearly displayed. However, on the tour of the facility three emergency exit doors were observed to have either a 'snib' or dead bolt catch in place at the top of the door frames, that would hinder emergency egress. A fourth door in the dining room was observed during meal service to be locked and obstructed by residents' walkers stored in front of the exit door.	External door catches and storage of equipment, hinders emergency egress.	Ensure all exit doors can be safely exited at all times. 30 days
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management</p>	PA Moderate	The surveillance data report for June 2021 identified six respiratory tract infections, and although the GP had reviewed these residents, the trend had not been acted upon.	Surveillance data is not consistently acted upon.	Ensure surveillance data is consistently acted upon.

in a timely manner.				60 days
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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.