

The Ultimate Care Group Limited - Ultimate Care Madison

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 Madison	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 19 October 2021	End date: 20 October 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:	48	

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 Madison can provide care for up to 57 residents requiring rest home and hospital (geriatric and medical) level care. There were 48 residents at that facility on the first day of the audit.

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

There are areas identified as requiring improvement relating to: quality data evaluation, and complaints procedures.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Information regarding the Health and Disability Commissioners' Code of Health and Disability Consumers' Rights; the complaints process; and the Health and Disability Advocacy Service is made available to residents and their families on admission and is accessible to residents and their families in the facility.

Staff interviews demonstrate an understanding of residents' rights and their obligation to uphold these. Residents and families confirmed that residents' rights are upheld.

Residents have their needs met in a manner that respects their cultural values and beliefs, including residents who identify themselves as Māori. Informed consent is practised, and written consent is obtained when required.

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

Staff communicate with residents and family members following incidents and this is recorded in the resident's file. Interviews confirmed that the environment is conducive to communication and that staff are respectful of residents' needs.

There is a documented and implemented complaints management system that aligns with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights.

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

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

An experienced and suitably qualified facility manager ensures the management of the facility and has been in this role for 13 years. The facility manager is supported by a clinical services manager, who has been in this role for 10 months, and who oversees the clinical and care services in the facility. A regional clinical lead and regional manager support the facility's managers in their roles.

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

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

Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported.

An annual education and training programme has been implemented and there is a current plan in place.

Appropriate employment processes are adhered to. All employees have an annual staff appraisal completed.

There is a roster tool that ensures sufficient and appropriate staff coverage for the effective delivery of care and support.

There are policies and procedures in place to ensure the privacy and confidentiality of resident information.

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.		Standards applicable to this service fully attained.
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Registered nurses assess residents on admission. The initial care plan guides care and service provision during the first three weeks after a resident's admission.

The interRAI assessments are used to identify residents' needs and 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. Short-term care plans are developed for acute problems. Residents' files reviewed demonstrated evaluations were completed at least six-monthly. Residents and their families are involved in the care planning process and notified regarding any changes in a resident's health status.

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

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

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

The food service meets the nutritional needs of the residents. All meals are prepared on-site. There is a food control plan which is current and displayed. Kitchen staff have food safety qualifications. The kitchen was clean and meets food safety standards. Residents and family confirmed satisfaction with meals provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness and an approved fire evacuation plan. Waste and hazardous substances are managed safely. Staff use protective equipment and clothing where required.

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

Residents' rooms provide single accommodation and are an appropriate size to allow for care to be provided, and for the safe use and manoeuvring of mobility aids. Bathroom and showering facilities are provided throughout the facility and are easily accessible. The facility has a monitored call bell system for residents to summon help, when needed, in a timely manner.

Cleaning and on-site laundry services, provided seven days a week by household staff, are monitored.

There are sufficient communal areas within the rest home and hospital areas that include lounge and dining areas. An external courtyard area is accessible for residents using mobility aids and external gardens are accessible with suitable pathways and shade areas.

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

Essential security systems are in place to ensure resident safety.

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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Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by a restraint coordinator who is a registered nurse. On the day of the on-site audit, there was one resident using restraint and no residents using enablers. 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.
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The infection control programme is appropriate to the size and complexity of the service. The infection control nurse is a registered nurse. Infection data is collated, analysed, and trended. Monthly surveillance data is reported to staff and to the Ultimate Care Group national support office. There have been no outbreaks 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	48	0	1	1	0	0
Criteria	0	99	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ultimate Care (UC) Madison has policies and procedures that align with the requirements of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Training on the Code is included as part of the orientation process for all staff employed and in ongoing staff training.</p> <p>Family and residents have been provided with information on admission, which includes the Code. Interviews with residents and family demonstrated an understanding of the Code. Staff interviews confirmed that staff respect privacy, and support residents in making choices, where able.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>A consent policy is in place to ensure that a resident who is competent to consent to a treatment or procedure, has been given information to reach an independent decision. The policy includes a definition of consent and how this will be facilitated and obtained.</p> <p>Observations evidenced that residents or their EPOA sign informed consents in line with legislation.</p> <p>All staff interviewed, including non-clinical staff, demonstrated they are cognisant of the</p>

		<p>procedures to uphold informed consent.</p> <p>The FM and CSM discuss informed consent with residents and family during admission and care planning. This includes consent for resuscitation and advance directives. Advance care planning and EPOA are documented. File reviews and staff interviews demonstrated that advance directives, resuscitation orders and EPOA were completed for residents in accordance with policy.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>There is an advocacy policy and procedure to ensure that residents and their families have a right to be represented and express views or concerns about their situation. It includes making them aware of the availability of advocacy services and supports access to advocacy services.</p> <p>Information regarding the availability of the Nationwide Health and Disability Advocacy Service is included in the information pack provided to residents and family on admission. The complaints policy also includes making residents aware of their right to advocacy when making a complaint.</p> <p>Interviews with residents and family confirmed that they are aware of the right to advocacy.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit, in accordance with the Covid-19 regulations.</p> <p>The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events. The service provides assistance to ensure that the residents are able to participate in these as much as they wish and can do so safely.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Moderate	<p>There is a complaints policy in place. The complaints procedure is provided to residents and relatives on entry to the service. The FM maintains a record of all complaints, both verbal and written, by using a complaint register. Documentation including follow-up letters and resolution, demonstrated that complaints are being managed in line with Right 10 of the Code, with the exception of clinical oversight.</p> <p>Five complaints have been logged, in 2021. All complaints were acknowledged, and a comprehensive investigation was completed, the complainant was kept informed of a lengthy investigation delays timeframes. A follow-up letter was sent to the complainant or a meeting held to discuss the complaint and outcome of the investigation. Complaints all included a section to</p>

		<p>sign off on the register once resolved. However, where complaints related to clinical issues are raised, these are not always identified as requiring clinical oversight. In complaints involving human resource management, policy is followed and action taken but this is not documented as a part of the closure of the complaint. Staff meeting minutes mention complaints but there is no rationale regarding the outcome of complaints or learning for staff to prevent further occurrences.</p> <p>There have been no complaints to the district health board (DHB), ministry of health (MOH) or HDC.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information on the Code and Nationwide Health and Disability Advocacy Services is available and displayed in the facility. The facility manager (FM) or clinical services manager (CSM) explains the information provided to residents and families in the pre-admission and admission pack, such as the Code, advocacy services, and the complaints process, during the admission process to ensure understanding,</p> <p>Resident interviews confirmed they understand their rights and felt that staff upheld these.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Ultimate Care Madison has a philosophy that ensures the residents' rights to privacy and dignity are always recognised and respected. Residents are encouraged to maintain their independence. Outings are encouraged and supported for the residents who are able. Staff interviewed stated that they encourage the residents' independence by encouraging them to be as active as possible.</p> <p>During the audit, caregivers were sighted knocking on residents' bedroom doors prior to entering and ensure doors are shut when cares are being given. Resident and family interviews confirmed that privacy is being respected.</p> <p>Resident files reviewed identified that cultural and/or spiritual values, and individual preferences were identified on admission with family involvement and these were documented in the residents' care plans. This included cultural, religious, social, and ethnic needs. There are clear instructions provided to residents on entry and in their admission agreement, regarding responsibilities of personal belongings.</p> <p>The organisation has a policy on sexuality and intimacy that provides guidelines for staff in managing expressions of sexuality, and defines appropriate expressions of sexuality. Resident and family interviews and observation confirmed that residents had access to a hairdressing salon at the facility and could wear clothing and makeup of their choice.</p>

		<p>The relatives interviewed stated their family was welcomed into the facility. Personal pictures were put up to assist residents to orientate to their new environment. Interviews with the caregivers described how choice is incorporated into resident cares.</p> <p>There is an abuse and neglect policy that sets out the guidelines to prevent, identify, report any incidences of abuse and neglect. Staff receive orientation and mandatory annual training on abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Ultimate Care Madison has a Māori health plan that identifies how Ultimate Care Group (UCG) will respond to Māori cultural needs and beliefs in relation to illness. Staff receive training in cultural safety as part the mandatory annual education programme. The cultural needs of residents and their whānau are documented in mandatory admission assessments.</p> <p>There were no residents within the service on audit days who identified as Māori.</p> <p>Staff interviews described awareness of the support for staff for providing culturally appropriate care for Māori residents and their families, would be sourced externally or through UC Madison when required. Interviews also confirmed awareness of the importance of involving whānau in the delivery of care.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Ultimate Care Madison recognises the cultural diversity of its residents, families, and staff. The facility's policies and procedures reflect key relationships with churches and community groups. Diverse beliefs, cultures, personalities, skills and life experiences are acknowledged.</p> <p>The residents' personal needs and values were identified on admission and this information is gathered from previous interRAI assessments and interviews with residents, family and/or enduring power of attorney (EPOA). All care plans reviewed included the resident's social, spiritual and cultural needs. Caregivers were able to give examples of how they meet the individual needs of each resident they care for. A pastoral visitor (minister) is available to offer spiritual services for residents.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The service has organisation-wide policies and procedures to protect residents from any form of discrimination, coercion, harassment, or exploitation. Relevant policies and procedures have been implemented. Staff orientation and in-service education provide ongoing awareness around prevention of any discrimination, coercion, and harassment.</p>

		<p>The FM and caregiver interviews, demonstrated a clear understanding of professional boundaries. Documented job descriptions and code of conduct describe the functions and limitations of each position. Family interviewed acknowledged the openness of the service and stated that staff were all approachable, and welcoming.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	FA	<p>The facility implements UCG policies and procedures. These are current and based on good practice and current legislation and guidelines. Policies align with the Health and Disability Services Standards and ensure safe, current evidence-based practice.</p> <p>The annual training programme provided to all staff includes: the implementation of policy and procedures, good practice and service delivery.</p> <p>Clinical consultation and expertise are available through UCG's clinical leadership team.</p> <p>Staff and resident interviews, progress notes in residents' file notes and observation of service delivery confirmed that resident care was based on good practice guidelines.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure alert staff to their responsibility to notify family/EPOA of any accident/incident that occurs.</p> <p>Electronic accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident, whenever possible families or emergency contacts are informed. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The admission agreement lists interpreter services as an excluded service, although UC Madison does not charge for this service.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</p> <p>There is consultation and communication with residents/relatives through regular two-monthly meetings, newsletters and emails.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation</p>	FA	<p>Ultimate Care Madison is part of the UCG Limited with the executive team providing direction to the service. The goals and direction of the service for UC Madison are documented in the annual</p>

<p>ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>business, and quality and risk plan.</p> <p>Oversight and management of the facility is provided by a FM who has been in this management role for 13 years and has with 7 years' previous experience as a caregiver in aged care. The FM is supported by the CSM who has been in this role for 10 months. The CSM is an experienced (in this lead role) registered nurse (RN) with experience in aged care. Both managers are supported by a regional manager and clinical specialist support from UCG head office.</p> <p>Ultimate Care Madison provides residential services for up to 57 residents requiring rest home or hospital (geriatric or medical) levels of care. There are 54 dual-purpose rooms, and 3 rooms that are able to be used as double rooms for married couples when required (these rooms were ll single occupancy on the days of audit). On the day of audit there were 48 residents – 26 at rest home level care and 22 at hospital level of care. All residents resided in dual-purpose rooms (verified).</p> <p>The service holds contracts with the DHB for aged-related care, respite care and day care and long-term chronic conditions. At the time of audit all residents were under the Aged Related Residential Care (ARRC) DHB agreement.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During a temporary absence, of the FM, a roving UC facility manager covers the role with the support of the regional manager, and the CSM role is covered by a RN.</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>There are policies and procedures, and associated implementation systems to ensure that the facility meets accepted good practice and are adhering to relevant standards, including standards relating to the Health and Disability Services (Safety) Act 2001. Policies are regularly reviewed at head office level and all are current. New policies or changes to policy are communicated to staff.</p> <p>There is an implemented annual schedule of internal audits. Areas of non-compliance from the internal audits include the implementation of a corrective action plan with sign-off by the FM when it is completed. However, analysis of trends and evaluation of outcomes requires improvement.</p> <p>Since the last audit a new reporting tool called the manager's reflective report has been</p>

		<p>developed and enacted to capture quality improvement initiatives as a result of internal audit findings. Quality improvement initiatives include the incorporation of improved clinical indicators into the everyday life of the facility, such as: falls reduction with sensor mats; resident weight loss assessments; the improvement of food services and a reduction in infections. Strategies to improve staff levels and retainment and a move towards a stable staff have included the employment of a new CSM; extra cleaner; staff to assist caregivers with housekeeping duties such as bed making; the employment of a skilled maintenance person, and an extensive recruiting drive for both RNs and caregivers.</p> <p>An annual resident and relative satisfaction survey was completed in 2021, with an average rating of 95% approval. Corrective action plans implemented for the satisfaction survey include the employment of a maintenance/ground's person with improvements to the garden environment and routine maintenance, and the training of kitchen staff to ensure improvement of the evening meals.</p> <p>Ultimate Care Madison has a trained health and safety officer, the FM, who is supported by a health and safety team made up of all areas of staff.</p> <p>Staff meetings (five various meetings; quality, health and safety, caregivers, RNs, infection control and prevention) that were all held monthly have been moved into a comprehensive once monthly meeting for all staff quality and staff meeting, with good staff attendance. These meetings include (but are not limited to): quality, restraint, health and safety and infection control; care issues, staffing, maintenance, activities, cleaning and laundry, foods service, accident/incidents reporting, staff education and competencies, updated policy and procedures, and internal audit results and associated corrective actions.</p> <p>Hazards are identified on hazard identification forms. The hazard register is relevant to the service and has been regularly reviewed and updated. Ultimate Care Madison collects information on staff accidents/incidents and provides follow-up where required.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Managers interviewed described awareness of their responsibilities in relation to essential notification and incident reporting. Notifications to HealthCERT under Section 31 were noted for the appointment of the new CSM and the admission of a resident with a stage four pressure injury.</p> <p>There is an electronic system to record and report all resident clinical incidents/accidents. The incident reporting system links to the quality management system. Review of incident reporting indicated that whenever possible families or emergency contacts are informed of unanticipated events and changes in a resident's clinical condition. The general practitioner (GP) was notified</p>

		<p>when required. Staff interviewed confirmed that clinical incidents/accidents are reported to the RN in charge in a timely manner.</p> <p>Clinical incidents/accidents reviewed evidenced documentation and evaluation by the CSM. Associated progress notes recorded the detailed interventions commenced. Neurological observations were completed for unwitnessed falls and suspected head injuries as per best practice.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Staff files reviewed evidenced implementation of the recruitment process, employment contracts and completed orientation. Human resource issues around code of conduct compliance are followed up as per policy but are not always documented in the complaints register (refer 1.1.13).</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed.</p> <p>A competency programme is in place. Core competencies are completed annually, and a record of completion is maintained. File reviews evidenced that annual performance appraisals have been completed for staff employed greater than one year. A record of practising certificates is maintained.</p> <p>There is current two-year education programme in place for all staff. Education and training for clinical staff is linked to external education provided by the DHB. Registered nurse, specific training viewed included: syringe driver, first aid certificates and interRAI. There are four RNs who are interRAI qualified and all RNs have a current first aid certificate. Caregivers complete Careerforce training.</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>	FA	<p>Duty rosters are completed by the FM with input from the CSM and are guided by a base roster. The FM explained that rostering was based on the occupancy in the facility; the level of acuity; the skill mix and experience of staff; and the daily workload, inclusive of roster allocation tool to ensure staffing levels are maintained at a safe level.</p> <p>The facility aims to have a RN rostered on to cover the morning and afternoon shifts for the hospital care service and one RN at night across the facility. A sample of rosters established that RN cover is ensured 24/7 and unplanned RN staff absences are filled in by an agency RN. The CSM takes responsibility for the oversight of the rest home level care. A senior, medication competent caregiver has been rostered on to support the CSM. Part time caregivers fill the roster</p>

		<p>caregiving gaps currently with the assistance of the FM who helps out when required.</p> <p>Across the facility there are twelve caregivers, (six morning and six afternoon) with a mix of long and short shifts rostered in the morning and afternoon shifts (this does not include the senior caregiver to assist the CSM in the rest home who has responsibility for medication management at that level of care), and two at night seven days per week. The FM's roster allocation tool is updated and notes the short fall in caregiver and RN numbers.</p> <p>The FM, with the assistance of head office human resources staff, is currently actively advertising for and recruiting for vacant positions, and a RN and caregiver were interviewed and offered and accepted positions during this audit.</p> <p>The FM and CSM are rostered on call to support the facility after hours and staff have an internal UC Madison "on call" telephone RN clinical service as back up.</p> <p>Residents and relatives on interviews stated they were satisfied with care provided by staff.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Residents' records and medication charts are managed electronically. Residents' information, including progress notes, are entered into the resident's record in an accurate and timely manner. The name and designation of the person making the entry is identifiable. Residents' progress notes are completed every shift, detailing resident's response to service provision.</p> <p>There are policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff interviews confirmed an awareness of their obligations to maintain the confidentiality of resident information. Resident care and support information can be accessed in a timely manner and is protected from unauthorised access. Electronic password protection and any hard copy information is locked away when not in use. Documentation containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public.</p> <p>Each resident's information is maintained in an individual, uniquely identifiable record. Records include information obtained on admission, with input from the resident's family and resident where applicable.</p> <p>The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals.</p>
<p>Standard 1.3.1: Entry To Services</p>	<p>FA</p>	<p>Needs assessment and service coordination (NASC) assessments are completed for each patient's entry to the service. The service communicates with needs assessors and other</p>

<p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>appropriate agencies prior to the resident's admission regarding the resident's level of care requirements. There is an information pack provided to all residents and their families prior to admission. Review of residents' files confirmed entry to service processes are implemented, ensuring compliance with entry criteria.</p> <p>Residents and family members interviewed stated they were satisfied with the admission process and that it had been completed in a timely manner. Information about UC Madison had been made available to them. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Transition, exit, discharge, or transfer is managed in a planned and coordinated manner.</p> <p>Interviews with RNs and review of residents' files confirmed there is open communication between services, the resident, and the family/whānau. Relevant information is documented and communicated to health providers. A transfer form accompanies residents when a patient is moved to another service or facility. Follow-up occurs to check that the resident is settled.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>A current medication management policy identifies all aspects of medicine management in line with relevant legislation and guidelines.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices are in line with legislation, protocols, and guidelines. The required three-monthly reviews by the GP were recorded electronically. Resident allergies and sensitivities were documented on the electronic medication chart and in the resident's electronic record.</p> <p>The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. There are no standing orders used at the facility.</p> <p>Review of the medication fridge evidenced that the service does not store or hold vaccines and interview with the RN confirmed this. The medication refrigerator temperatures and medication room temperatures are monitored daily.</p> <p>Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration. Weekly checks of medications and six-monthly stocktakes are conducted in line with policy and legislation.</p>

		<p>The staff observed administering medication demonstrated knowledge and at interview demonstrated clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures. The RN oversees the use of all pro re nata (PRN) medicines, and documentation made regarding effectiveness on the electronic medication record, and in the progress notes was sighted. Current medication competencies were evident in staff files.</p> <p>There were no residents self-administering medication at the time of the audit.</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>	FA	<p>All meals are prepared on site. The seasonal menu has been reviewed by a dietitian. The food control plan's expiry date is February 2022.</p> <p>The kitchen was observed to be clean and cleaning schedules were sighted.</p> <p>All kitchen staff have relevant food hygiene and infection control training.</p> <p>A nutritional assessment is undertaken for each resident on admission by a 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. Supplements are provided to residents with identified weight loss problems as medically required.</p> <p>Residents were seen to be given enough time to eat their meal and assistance was provided when necessary. There were enough staff to ensure appropriate assistance was available. Residents and families interviewed stated that they were satisfied with the meals provided.</p> <p>All aspects of food procurement, production, preparation, storage, delivery, and disposal sighted at the time of the audit comply with current legislation and guidelines. The cook is responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately in fridges, a freezer and 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. Food temperatures are monitored appropriately and recorded daily.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p>	FA	<p>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</p>

<p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>decline to entry. The resident would be declined entry if not within the scope of the service or if a bed was not available. A waiting list is maintained.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The initial nursing assessments are completed using the electronic system. Assessments reflect data from a range of sources, including: the NASC, the resident; family/whānau; the GP and specialists.</p> <p>The initial care plan guides care for the first three weeks of the resident's admission. Registered nurses complete the interRAI assessment within the required timeframes. The LTCP is based on the interRAI assessment outcomes and the initial nursing assessments.</p> <p>Policies and protocols are in place to ensure continuity of service delivery.</p> <p>All residents have current interRAI assessments completed by one of four trained interRAI assessors on site.</p> <p>Residents and family members confirmed involvement with the assessment process.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Long-term care plans are developed with the resident and family/whānau involvement. Short-term care plans are developed for the management of acute problems. All residents' files sampled had individualised LTCPs with interventions to meet the needs of the residents. Care plans demonstrated service integration with clinical records, activities notes, and medical and allied health professionals' notes and letters.</p> <p>Interviews with residents confirmed they have input into their care planning and review, and that the care provided met their needs.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Review of residents' care plans demonstrated detailed interventions based on assessed needs, desired outcomes, and resident's goals.</p> <p>The GP documentation and records reviewed were current.</p> <p>Physiotherapy input is provided weekly to the facility. The physiotherapist sees all new admissions, residents who have sustained a fall and for changes to moving and handling assessments.</p>

		<p>Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs. There is evidence of wound care products available at the facility and where wounds required additional specialist input, this was initiated.</p> <p>Monthly observations such as weight and blood pressure are completed and are up to date.</p> <p>The nursing progress notes are recorded and maintained. Family communication is recorded. Interviews with residents and families confirmed that care and treatment met residents' needs.</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>	FA	<p>The residents' activities programme is implemented by a diversional therapist. Activities for the residents are provided five days a week, Monday to Friday 9am to 4pm. Activities on the weekend, public holidays and when the diversional therapist is on leave are provided by volunteers.</p> <p>The activities programme was displayed on the residents' noticeboards. The activities programme provides variety in the content and includes a range of activities which incorporate: education; leisure; cultural; spiritual and community events. Church services are held weekly. Regular van outings into the community are arranged for residents who are able.</p> <p>The residents' activities assessments are completed by the diversional therapist within three weeks of the residents' admission to the facility in conjunction with the admitting RN. Information on residents' interests, family and previous occupations is gathered during the interview with the resident and/or 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.</p> <p>The residents and their families interviewed reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging and enjoying a variety of activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it is reported to the RN and CSM.</p> <p>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. The service develops short-term care plans for the management of short-term acute</p>

		<p>problems. This includes problems such as infections, wounds, and falls. Short-term care plans, including wound care plans, are reviewed and signed off when the problem is resolved.</p> <p>Residents and families interviewed confirmed involvement in the evaluation process and any resulting changes. Contact with family was verified in the resident's records.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Where needed, referrals are sent to ensure other health services, including specialist care and this 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.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>The service has documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. Waste is appropriately managed. Chemicals were secured in designated locked cupboards. Chemicals were labelled, and safety datasheets were available and accessible to staff. Safe chemical handling training has been provided by the contracted supplier. Gloves, and aprons, are available, and staff were observed wearing personal protective equipment/clothing (PPE) while carrying out their duties. The maintenance person interviewed described the safe management of hazardous material.</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>	FA	<p>A current building warrant of fitness is displayed in the entrance to the facility. Buildings, plant, and equipment comply with relevant legislation.</p> <p>A preventative and reactive maintenance schedule is implemented. This includes monthly maintenance checks of all areas and specified equipment such as hoists. Staff identify maintenance issues on an electronic system. This information is reviewed daily, or more frequently, by the maintenance person and attended to as required. Interviews confirmed staff awareness of the processes for maintenance requests and that repairs were conducted in a timely manner.</p> <p>Interviews with staff and visual inspection confirmed there is adequate equipment available to support care. The facility has an up to date annual test and tag programme. Evidence of checking and calibration of biomedical equipment, such as hoists was sighted. There is a system</p>

		<p>to ensure that the facility van that is used for residents' outings is routinely maintained. Inspection confirmed that the van has a current registration, warrant of fitness, first aid kit, and a fire extinguisher. Staff interviews and documentation evidenced that those staff who drive the van have a current driver's licence.</p> <p>Hot water temperatures are assayed monthly. A review of temperature assays and interview with the maintenance person confirmed that if hot water temperatures are found to be above the recommended safe temperature, action is taken by a plumber.</p> <p>All resident areas can be accessed with mobility aides. There are accessible internal and external courtyards and patios. All external garden areas have outdoor seating and shade and can be accessed freely by residents and their visitors.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All resident rooms throughout the facility are single rooms and provide adequate space for resident cares to be provided, as sighted during the audit. In addition, there are communal mobility bathrooms, with showers and toilets, of sufficient size for mobility aids. These are located within easy distance of rooms that do not have shared bathrooms. Visitor toilet facilities are available.</p> <p>Residents interviewed stated their privacy and dignity is maintained while attending to their personal cares and hygiene. The communal toilets are signed and identifiable and include vacant/in-use signs. There are easy clean flooring and fixtures, and handrails are appropriately placed.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Residents have their own room, and each is of sufficient size to allow residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. All rooms are dual purpose and have sufficient space to facilitate the use of a hoist. Observation and interviews with residents confirmed that there was enough space to accommodate: personal items; furniture; equipment and staff as required.</p> <p>Residents and their families can personalise the resident's room. Furniture in residents' rooms include residents' own personal pieces and memorabilia; is appropriate to the setting and is arranged in a manner that enables residents to mobilise freely.</p> <p>There are designated areas within the facility to store equipment such as: wheel chairs; walking frames; commodes and hoists, tidily.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are dining rooms and lounges at each end of the facility and a central kitchen. All internal communal areas have seating and external views. Areas can be easily accessed by residents, family and staff. There are areas that are available for residents to access with their visitors for privacy, if they wish. Observation and interviews with residents and family confirmed that residents can move freely around the facility and that the accommodation meets residents' needs.</p> <p>There are areas for storing activities equipment and resources. There are areas in each wing, including lounge areas, that are used for activities.</p> <p>Most residents were observed to have their meals with other residents in the communal dining rooms, but can have their meal in their own room, if they wish.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry and cleaning services are provided seven days a week. Sampled rosters confirmed that cleaning and laundry duties are rostered each day. Visual inspection of the on-site laundry demonstrated the implementation of a clean/dirty process for the hygienic washing, drying and handling of personal clothes and facility linen. The safe and hygienic collection and transport of laundry items into relevant colour containers was witnessed. Household and laundry personnel interviewed demonstrated knowledge of the process to handle and wash infectious items when required.</p> <p>Residents clothing is labelled and personally delivered from the laundry, as observed. Residents and families confirmed satisfaction with laundry services in interviews and in satisfaction surveys.</p> <p>Two cleaners are on duty Monday-Friday, one cleaner during the weekend. Cleaning duties and procedures are documented to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. Household personnel interviewed are aware of the requirement to keep their cleaning trolleys in sight. Chemical bottles/cans in storage and in use were noted to be appropriately labelled.</p> <p>Cleaning and laundry services are monitored for effectiveness.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and</p>	<p>FA</p>	<p>Staff files and training records demonstrated that orientation and mandatory training includes emergency and disaster procedures and fire safety. An approved fire evacuation plan was sighted. Interviews with staff and review of documentation confirmed that fire drills are conducted at least six-monthly. There is a sprinkler system installed throughout the facility and exit signage</p>

<p>security situations.</p>		<p>displayed. Staff interviews, and training records confirm that fire wardens received warden training and staff have undertaken fire training.</p> <p>The staff competency register evidenced that there is a system to ensure staff maintain first aid currency. In addition to all RNs, there are other staff, including activities staff with current first aid certificates.</p> <p>The facility has sufficient supplies to sustain staff and residents in an emergency situation. Alternative energy and utility sources are available in the event of the main supplies failing. These include: a barbeque and gas for cooking; emergency lighting; and enough food, water, dressings and continence supplies. The service's emergency plan includes considerations of all levels of resident need.</p> <p>All hand basins used for hand washing, including those in residents' rooms, have access to flowing soap and paper towels. These were observed to be used correctly by staff and visitors.</p> <p>Call bells are available to summon assistance in all resident rooms and bathrooms. Call bells are checked monthly by the maintenance person. Observation and resident interviews confirmed that call bells are answered promptly.</p> <p>Security systems are in place to ensure the protection and safety of residents, visitors and staff. These include visitors signing in and out of the building and the facility being locked in the evenings with restricted entry after hours.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Ultimate Care Madison provides an environment that minimises the risk of infection to residents, staff, and visitors by implementing an infection prevention and control programme. The CSM is the infection control nurse (ICN) and has access to external specialist advice from the DHB infection control specialists, and microbiologists when required. A documented role description for the ICN, including role and responsibilities, is in place. The ICN reports to the FM and the UCG head of resident risk.</p> <p>The infection control programme is appropriate for the size and complexity of the service. The</p>

		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.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICN is responsible for implementing the infection control programme.</p> <p>The ICN stated that there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the facility's meetings. The ICN has access to all relevant resident data to undertake surveillance, internal audits, and investigations. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</p> <p>Infection prevention and control resources were available should a resident infection or outbreak occur.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>Ultimate Care Group has documented policies and procedures in place that reflect current best practice relating to infection prevention and control.</p> <p>Staff were observed to be complying with the infection control policies and procedures. Staffs demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The ICN has completed training for the role.</p> <p>Staff education on infection prevention and control is provided by the ICN and external infection control specialists. All staff attend infection prevention and control training. Records of attendance are maintained. Staff interviewed confirmed their understanding of how to implement infection prevention and control activities into their practice.</p> <p>Covid-19 information is available to all visitors to the facility. Ministry of Health information was available on site.</p>

		Education for residents occurs at the residents' meetings and informally on a one-to-one basis. Topics covered include hand hygiene, Covid-19 information and the requirement to stay in their rooms if they have an infection.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The UCG surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal infection prevention and control audits are completed. Infection data is collated monthly and is submitted to Ultimate Care national support office. Monthly surveillance data is collated and analysed to identify any trends, possible aetiology, and any required actions. This data is reported at the quality and staff meetings. The UCG reflection report is displayed on the staff noticeboard. There have been no outbreaks since the last audit.
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 CSM, who provides support and oversight for enabler and restraint management in the facility. The restraint coordinator is conversant with restraint policies and procedures. On the day of the audit, one resident was using restraints, that included bedrails and a lap belt. No residents were using enablers. A similar process is followed for the use of enablers as is used for any restraint use. Restraint is used as a last resort when all alternatives have been explored. This was evident from interviews with staff who are actively involved in the ongoing process of restraint minimisation. Regular training occurs. Review of restraint and enabler use is completed and discussed at all quality and clinical meetings.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes	FA	The restraint approval process is described in the restraint minimisation policy. The CSM has a job description that defines the role and responsibility of the restraint coordinator. An assessment and management process is followed for the use of both restraints and enablers which ensures the ongoing safety and wellbeing of residents. This includes cultural considerations. The restraint coordinator explained the process for determining approval, for

(including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		<p>recording, monitoring, and evaluating any restraints or enablers used. The GP at interview confirmed their involvement with the restraint approval process. Family/whānau approval is gained should any resident be unable to do so and any impact on family is also considered. This was evidenced by documentation and files viewed.</p> <p>Training for all staff occurs at orientation and the RNs and caregivers complete a restraint competency annually.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The restraint/enabler policy details the process for assessment. Assessment covers the need, alternatives attempted, risk, cultural needs, impact on the family, any relevant life events, any advance directives, expected outcomes and when the restraint will end. Completed assessment templates were sighted evidencing assessment, including consultation with family and GP.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Restraint and enablers are only used to maintain resident safety, and only as a last resort. The restraint coordinator discusses alternatives with the resident, family/whānau, GP and staff. Once approved and in use, the restraint is closely monitored and documented. Documentation includes the method approved, when it should be applied, frequency of checks and when it should end. It also details the date, time of application and removal, risk/safety checks, food/fluid intake, pressure area care, toileting, and social interaction during the process.</p> <p>A restraint register is maintained and reviewed by the restraint coordinator who shares the information with staff at the quality and clinical meetings.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>All restraints are reviewed and evaluated as per UCG policy and the requirements of the standard. Use of restraints and enablers is evaluated three-monthly or more often according to identified risk. The evaluation includes a review of the process and documentation, including the resident's care plan and risk assessments, future options to eliminate use and the impact and outcomes achieved. Family/whānau are included in the evaluation process. Evaluations are discussed at the quality and clinical meetings.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring</p>	FA	<p>A review of documentation and interview with the CSM demonstrated the monitoring and quality review of the use of restraints. The internal audit schedule was reviewed and included review of restraint minimisation reviews. The content of the internal audits included the effectiveness of</p>

and quality review of their use of restraint.		restraints, staff compliance, safety and cultural considerations. Staff monitor restraint related adverse events while restraint is in use. Any changes to policies, guidelines or education are implemented if indicated. Data reviewed, minutes and interviews with staff, including RNs and caregivers, confirmed that restraint is only used as a last resort.
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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 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	<p>PA</p> <p>Moderate</p>	<p>Complaints are approached as per policy with acknowledgements, and investigations carried out with records maintained in a register.</p> <p>However, clinical and human resource oversight is not always followed, and staff meetings do not always inform staff.</p>	<p>(i) Clinical aspects of complaints are not always identified to clinical management for follow up with clinical oversight.</p> <p>(ii) In respect of complaints involving human resource issues, there is no documentation of human resource policy being followed in the complaints register.</p> <p>(iii) Outcomes and rationale of the complaint are not always disclosed at staff meetings to educate and prevent recurrence.</p>	<p>(i) Clinical aspects of complaints need to have clinical management oversight as a part of the investigation and implementation of improvements.</p> <p>(ii) Human resource policy relating to employment code of conduct should be followed and notation of this process stated within the outcome of the complaint.</p> <p>(iii) Staff meetings should clearly outline the aspect of the complaint and the outcomes to educate staff and to prevent recurrence.</p>

				90 days
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	PA Low	<p>Corrective actions are raised from quality improvement data inclusive of internal audits, however, analysis of trends and evaluation of outcomes requires improvement.</p>	<p>(i) Outcomes for corrective actions are not documented, inclusive of evaluations prior to sign off.</p> <p>(ii) Quality, health and safety, staff meetings do not fully inform staff of evaluations and outcomes.</p>	<p>(i) Outcomes and evaluations of corrective actions should be documented.</p> <p>(ii) Quality, health and safety, staff meetings should clearly outline corrective actions and improvements.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.