

# The Ultimate Care Group Limited - Ultimate Care Oakland

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## 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:

<b>Legal entity:</b>	The Ultimate Care Group Limited
<b>Premises audited:</b>	Ultimate Care Oakland
<b>Services audited:</b>	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	Start date: 30 November 2021      End date: 1 December 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	79



# Executive summary of the audit

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## 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 Oakland provides residential disability (physical and intellectual), rest home and hospital (geriatric and medical) level care for up to 90 residents. The service is operated by Ultimate Care Group and managed by a facility manager and a clinical nurse manager. Occupancy on the first day of audit was 79. There have been no significant changes to the facility since the last audit.

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

Areas identified as requiring improvement relate to quality and risk management systems, medication management, food services, maintenance and facility specifications.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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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 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 is the governing body responsible for the services provided at the facility. The vision, mission and values of the organisation are documented and communicated to all concerned.

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

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

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

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

## Continuum of service delivery

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

The interRAI assessments are used to identify residents' needs and these are completed within the required timeframes. The nurse practitioner or nurse 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. Residents' files reviewed demonstrated evaluations were completed at least six-monthly. Residents and their relatives are 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 registered nurses and care givers 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. Kitchen staff have food safety qualifications. 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.		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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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.

Essential security systems are in place to ensure resident safety. Six-monthly trial evacuations are undertaken.

## 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 the restraint coordinator who is a registered nurse. On the day of the on-site audit, there were no residents using restraints or 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.

The infection prevention and control programme is appropriate to the size and complexity of the service. The infection control nurse is a registered nurse. Infection data is collated, analysed, and trended. Monthly surveillance data is reported to staff. There has been one outbreak since the previous audit.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	38	0	1	6	0	0
<b>Criteria</b>	0	84	0	1	8	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 Oakland has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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>Residents and their family are provided with information about the services Ultimate Care Oakland Hospital provides pre-admission, this includes its mission statement, philosophy, resident responsibilities, feedback options, and consent forms.</p> <p>In clinical records sampled, signed consent forms included, but was not limited to: consent for photographs, outings, storage of health records, and permission to share health information with family. A signed admission agreement was held for all residents. A signed resuscitation status form was sighted in all clinical files sampled, and some resident's files contained an advance directive. Staff interviewed discussed the principles of informed consent, and methods used to determine that the resident has understood the information provided. Residents and relatives interviewed confirmed they were provided information that contributed</p>

		to making informed decisions.
<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 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. 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>	FA	<p>There is a current complaints policy which aligns with Right 10 of the Code. Residents and family members receive information on the complaints processes on entry. Complaints records were reviewed and confirmed that the management of complaints was undertaken as per policy and good practice; letters of acknowledgement, investigation, communication, and evidence of complaint resolution was available. The complaints register records the details of the complaint, dates, actions taken and completion the date. Complaints are responded to and managed by the FM. Within the past year there had been one complaint to the district health board (DHB) and one complaint the Health and Disability Commissioner (HDC), both had been investigated and are now closed.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents are given a copy of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, and through discussion with staff on admission.</p> <p>The Code is displayed throughout the facility, together with information on advocacy services,</p>

		how to make a complaint, and feedback forms. Residents and family interviewed stated they would feel comfortable raising issues with staff and management.
<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>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Residents are encouraged to maintain their independence through involvement with community activities, and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values, and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</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>There is a current Māori health plan that guides staff in meeting the needs of the residents who identify as Māori. Any additional cultural support, if required would be accessed locally. This was confirmed during an interview with the facility and clinical managers.</p> <p>Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs. Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs.</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 Oakland recognises the cultural diversity of its residents, families, and staff. The facility's policies and procedures reflect key relationships with churches and community groups. Residents' diverse beliefs, cultures, personalities, skills, and life experiences are acknowledged. The residents' personal needs and values were identified on admission and this information is gathered from previous interRAI assessments and residents, family and/or enduring power of attorney (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>	<p>FA</p>	<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 facility manager (FM), clinical services manager (CSM), and caregivers interviewed, demonstrated a clear understanding of professional boundaries. Documented job descriptions describe the functions and limitations of each position. Families interviewed acknowledged the openness of the service and stated that staff were all approachable, and welcoming.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The facility implements Ultimate Care Group's (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 clinical leadership.</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</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<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. Records showed that these had been completed.</p> <p>There were no residents who required the services of an interpreter. Staff interviews advised that interpreter services would be sourced through the local DHB if required.</p> <p>The admission agreement lists advocacy and dietary services as excluded services although this service has not been charged for at Ultimate Care Oakland.</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</p>

		<p>entry of the scope of services and any items they have to pay for that are not covered by the agreement.</p> <p>Regular resident/relative meetings are held two-monthly.</p>
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Ultimate Care Oakland is part of the UCG Limited with the board, board committees, and executive team providing direction and support to the service. The organisation has vision, mission, and values in place which are resident centred. The organisation's values were displayed in the foyer of the facility. The FM reports monthly to a regional manager (RM) on key performance indicators.</p> <p>The service is managed by FM who holds relevant qualifications and has been in the role for one week, has a nursing background, and has performed similar roles for other providers for the past five years. The CSM has worked in this role at the facility for two years and has extensive aged care experience. Both managers maintain their knowledge of the sector through representation and participation in aged care forums and seminars, are registered nurses (RN) with current annual practicing certificates (APC). Over the last six months the RM has been carrying out both the FM and RM roles whilst the FM role was filled.</p> <p>The service provides hospital (geriatric and medical), rest home and residential disability (physical and intellectual) services for up to 90 residents. The facility is certified for 90 dual purpose beds. At the time of the audit, there were a total of 83 residents (79 on site as three residents were in Tauranga hospital and one was on leave) in the facility: 42 receiving rest home level care, and 36 receiving hospital level care inclusive of one long-term chronic health condition district health board (LTCHC DHB) contract and one Accident Compensation Commission contract (ACC). There were five residential disability services residents under Ministry of Health contracts (physical disability), four receiving hospital services, and one receiving rest home services.</p>
<p><b>Standard 1.2.2: Service Management</b></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>	FA	<p>The FM advised that in the short absence of the FM, the CSM would be responsible for the management of the facility. In the short absence of the CSM, a senior RN would cover the CSM's role. The RM would also provide support to staff during absences of the FM or CSM.</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. The UCG has made improvements to the electronic system with regard to this and the new FM is commencing work to improve corrective action outcomes and evaluations.</p> <p>Since the last audit a new reporting tool called the manager's reflective report has been 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, resident weight loss assessments, and a reduction in infections.</p> <p>An annual resident and relative satisfaction survey was completed in 2021, with an average rating of 97% approval. Areas requiring corrective actions include meal service, (73%), and services from external providers (80%). These results have just been collated and corrective action plans are yet to be actioned.</p> <p>Ultimate Care Oakland has two trained health and safety officers who support the FM.</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, 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, food 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.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service</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 FM, inability to cover RN shifts and the notifications of stage</p>



<p>and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>three and four pressure injuries, however, the call bell system failure found during audit was not reported (refer 1.4.7.5).</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 nurse practitioner (NP) was notified 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>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting, and validation of qualifications and APCs, where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB.</p> <p>There are seven of the eight trained and competent RNs plus one enrolled nurse (EN) who are maintaining their annual competency requirements to undertake interRAI assessments, and one new RN who has commenced training.</p> <p>Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider</p>	<p>FA</p>	<p>Duty rosters are completed by the FM with input from the CSM and are guided by a base</p>

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>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 at least two RNs rostered on to cover the morning and afternoon shifts for the 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 RN or EN. A senior, medication competent caregiver had been rostered on to support the RN if a replacement RN was not available. Part-time caregivers fill the roster caregiving gaps currently when required.</p> <p>The FM's roster allocation tool is updated and notes the caregiver and RN numbers being met.</p> <p>Support for the facility RNs after hours is provided by an internal UCG "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>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Needs Assessment and Service Coordination (NASC) assessments are completed for patient's entry to the service. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the resident's level of care requirements. There is an information pack provided to all residents and their families prior to admission. Review of residents' files confirmed entry to service processes 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 Ultimate Care Oakland had been made available to them. Residents' 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>PA Moderate</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/NP 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 are monitored weekly; however, the temperature of the medication rooms is not monitored.</p>

		<p>Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration. Weekly stocktakes 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. The RN oversees the use of all pro re nata (PRN) medicines; however, documentation regarding effectiveness of PRN medications administered is inconsistent.</p> <p>Current medication competencies were evident in staff files reviewed.</p> <p>There was one resident self-administering medication on the day of the audit. The resident had a current competency assessment, safe storage of their medication within their room and could describe the need and process for these when interviewed. All legal requirements had been met.</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>PA Moderate</p>	<p>All meals are prepared on site. The summer menu was in use on the day of audit. The menu has been reviewed by a dietitian, however, there is no current food control plan.</p> <p>There is a cleaning schedule in place and was sighted. However, areas of the kitchen and some items of equipment were not clean.</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 kitchen manager interviewed confirmed awareness of the dietary needs, likes and dislikes of residents. These are accommodated in daily meal planning.</p> <p>Residents were seen to be given enough time to eat their meal and assistance was provided when necessary. Residents and families interviewed stated that they were satisfied with the meals provided.</p> <p>The food manager is responsible for purchasing the food to meet the requirements of the menu plans. Food is stored in fridges, a freezer, and a pantry; however, not all food in the fridges and freezers was labelled and dated.</p> <p>Temperatures of fridges and the freezer are monitored and recorded daily, however, the</p>

		<p>temperature of food served to residents is inconsistently monitored and recorded.</p> <p>Dry food supplies are stored in the pantry and rotation of stock occurs.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service has a process in place if resident's access is declined. When residents are declined access to the service, residents and their family/whānau, the referring agency and NP are informed of the decline to entry. The resident would be declined entry if not within the scope of the service or if a bed was not available.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The initial nursing assessments which include: dietary needs, pressure injury, falls risk, and social history, are completed using the electronic system. Assessments reflect data from a range of sources, including: the resident; family/whānau; the NP and specialists.</p> <p>The initial care plan guides care for the first three weeks following 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 under the Aged Care Residential Care Contract have current interRAI assessments completed by one of the eight interRAI assessors on site.</p> <p>Residents and family members confirmed involvement with the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Long-term care plans are developed from information gathered during the first three weeks following admission and from the interRAI assessment. All residents' files sampled had individualised long-term care plans with goals and interventions to meet the needs of the residents. Care plans demonstrate service integration with clinical records, activities notes, and medical and allied health professionals' notes and letters.</p> <p>Activity assessments were completed by the activities staff within three weeks of admission. For YPDs, support plans are person centred, developed with the person and include wellbeing, community participation and meeting physical and health needs.</p> <p>Short-term care plans were evident in resident files and addressed short term concerns, for</p>

		<p>example, infections and post falls management.</p> <p>Interviews with residents confirmed that the care provided met their needs. There was documented evidence that EPOA/whānau had been involved in care planning.</p>
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Review of residents' care plans demonstrated detailed interventions based on assessed needs, desired outcomes, and resident's goals.</p> <p>The GP/NP documentation and records reviewed were current. The NP interviewed visits the facility weekly and an after-hours service is provided.</p> <p>Physiotherapy input is provided twice a week to the facility. The physiotherapist reviews new admissions, residents who have sustained a fall, and for changes to moving and handling requirements.</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, equipment, and products they require to meet those needs. There is evidence of wound care products available at the facility. Where wounds required additional specialist input, this is overseen by the NP.</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><b>Standard 1.3.7: Planned Activities</b></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 (DT) and two activities officers (AO). Activities for the residents are provided five days a week, 9.30am to 3.30pm. Activities at the weekend are resident driven and a range of resources are available for residents to access. The activities programme is displayed, and an individual copy is provided to the residents. 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 monthly.</p> <p>Four of the five residents under the YPD contract are over 65 years old. They are included in the activity programme, and they confirmed that they were satisfied with activities that were provided. The YPD resident under 65 years old confirmed that they were involved in the wider community and attended activities outside the facility three days a week. The DT interviewed arranges meetings each month for the residents under the YPD contract to facilitate targeted</p>

		<p>individual and group activities.</p> <p>The residents' activities assessments are completed by the DT 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 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.</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.</p> <p>The service develops short-term care plans for the management of short-term acute problems. Short-term care plans are reviewed and signed off when the problem is resolved.</p> <p>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 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</p>	PA Moderate	<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</p>

<p>are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>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 care duties. However, stocks were not always replenished, and splash guards were not available in sluice rooms. The maintenance person interviewed described the safe management of hazardous material.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Moderate</p>	<p>Ultimate Care Oakland has a current building warrant of fitness, which expires on 6 January 2022.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained, these are not always being followed as per a routine maintenance program and responses to maintenance requests.</p> <p>Hot water temperatures are checked monthly and were all less than 45 degrees Celsius. There have been no occasions when the hot water temperatures in resident areas were outside the 45 degrees requirements.</p> <p>Medical equipment and electrical appliances have been tested, tagged, and calibrated (due for review December 2021). There is a planned schedule to maintain regular and reactive maintenance of medical and electrical equipment, and the administrator interviewed could demonstrate progress.</p> <p>Oxygen usage and storage does not comply with policy and meet safety regulations.</p> <p>Residents were observed to mobilise safely within all areas of the facility. There are sufficient seating areas throughout the facilities with a variety of smaller and large lounge areas.</p> <p>The facility has residents and staff who smoke and there is a small area outside where smoking away from the residents is meant to occur. Both staff and residents smoke at various areas within the car parking and garden areas as well as on the balcony of the Rubcor wing.</p> <p>Care givers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs and as identified in the care plans.</p> <p>The gardens are maintained with safe paving, lawn and gardens. All communal areas both in and out of the building are easily accessible for residents using mobility aids with the use of extended ramps.</p>
<p>Standard 1.4.3: Toilet, Shower, And</p>	<p>FA</p>	<p>All resident rooms throughout the facility are single rooms, some with ensuites and some with</p>



<p><b>Bathing Facilities</b></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>		<p>shared bathrooms. There are two rooms which are able to be used as double rooms, one of which was in use by a couple at the time of audit.</p> <p>Rooms provide adequate space for resident care to be provided as sighted during the audit. In addition, there are communal mobility bathrooms, with showers and toilets, of sufficient size for mobility aids. These are located within easy distance of rooms that do not have ensuites. Visitor toilet facilities are available. Residents interviewed stated their privacy and dignity is maintained while attending to their personal cares and hygiene. The communal toilets are signed and identifiable, include vacant/in-use signs, and handrails are appropriately placed.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>The resident rooms are of sufficient size to meet the resident's assessed needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Care staff interviewed reported that rooms have sufficient room to allow cares to take place. The bedrooms were personalised to residents' taste.</p> <p>There are designated areas within the facility to store equipment such as wheelchairs, walking frames, commodes and hoists, tidily.</p>
<p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required.</p>
<p><b>Standard 1.4.6: Cleaning And Laundry Services</b></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>	PA Moderate	<p>Laundry is undertaken on site and dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. Maintenance and high cleaning of the laundry has not been carried out.</p> <p>There is a small designated cleaning team of two who have received appropriate training in the use of chemicals for cleaning purposes. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Sluice rooms are available for the disposal of soiled water/waste. Maintenance of high cleaning in sluice rooms has not been carried out.</p> <p>Hand washing facilities are available throughout the facility.</p>

		Cleaning and laundry processes are monitored through the internal audit programme.
<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>	PA Moderate	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Emergency and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service in 2008. A trial evacuation takes place with a copy sent to the New Zealand Fire Service, the most recent being in November 2021. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones, and gas BBQ's were sighted. All but food supplies meet the requirements for the 79 residents. Civil defence emergency boxes are within each wing.</p> <p>2000 litre water storage tanks are located in the complex. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. At the time of audit notices were displayed on the lift doors and the emergency alarms were functional. Half hourly rounding was occurring for those residents affected.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and open onto outside garden or small patio areas. Heating is provided by a variety of ways including wall heating or ceiling heaters in residents' rooms, and heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which</p>	FA	<p>Ultimate Care Oakland provides an environment that minimises the risk of infection to residents, staff, and visitors by implementing an infection prevention and control programme. The clinical manager is the infection control nurse (ICN) and has access to external specialist advice from the DHB infection control specialists, and microbiologists when required. A</p>

<p>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>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 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 (refer to 1.4.1.6.).</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<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. There is an infection control committee made up of the CM and the RNs. 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>	<p>FA</p>	<p>The UCG has documented policies and procedures in place that reflect current best practice relating to infection prevention and control.</p> <p>Staff were observed to be complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service</p>	<p>FA</p>	<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</p>

<p>providers, support staff, and consumers.</p>		<p>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> <p>Education for residents occurs 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.</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>FA</p>	<p>The UCG surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring.</p> <p>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.</p> <p>Short-term care plans are developed for infections, and reviewed and signed off when the infection resolves.</p> <p>Interview with the ICN confirmed there has been one outbreak (Respiratory Syncytial Virus) since the previous audit. Documentation reviewed and interview with the NP confirmed that this had been managed well and resolved within three weeks.</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>Policies and procedures meet the requirements of restraint minimisation and safe practice standards, and provide guidance on the safe use of both restraints and enablers. The clinical manager is the restraint coordinator, and a signed job description was sighted.</p> <p>On the day of audit there were no residents using restraints or enablers. Restraint is used as the last resort after all other alternatives have been tried. Use of the enabler is voluntary. This was evident from documentation reviewed and staff interviews. The restraint register was sighted. Restraint minimisation and safe practice education is provided to all staff at orientation/induction to the service and ongoing education is provided to staff annually.</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)
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Low	Corrective actions are raised from quality improvement data inclusive of internal audits, however, analysis of trends and evaluation of outcomes requires improvement.	(i) Outcomes for corrective actions are not documented, inclusive of evaluations prior to sign off.  (ii) Quality, health and safety, staff meetings do not fully inform staff of evaluations and outcomes.	(i) Outcomes and evaluations of corrective actions should be documented.  (ii) Quality, health and safety, staff meetings should clearly outline corrective actions and improvements.  90 days
Criterion 1.3.12.1	PA	The RN oversees the use of all PRN medications.	i) Effectiveness of PRN medications	i) Ensure that the

<p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>Moderate</p>	<p>However, documentation of the effectiveness of the medication given does not always occur. Administration of PRN medication occurs in the electronic records system progress notes, but not on the electronic medication management system. In ten out of eighteen medication charts reviewed, effectiveness of medication administered was not recorded on the electronic medication system on 62 occasions during the previous month.</p> <p>Temperature monitoring of the medication fridges occurs weekly, however, there is no monitoring of the temperature of the medication rooms. The clinical manager stated that they were unaware of the requirement to do this.</p>	<p>administered is not consistently documented on the electronic medication system.</p> <p>ii) The temperature of the medication rooms is not recorded as per UCG policy.</p>	<p>documentation of the effectiveness of all PRN medication administered is documented on the electronic medication management system.</p> <p>ii) Ensure that the temperature of the medication rooms is monitored and recorded in accordance with UCG policy.</p> <p>30 days</p>
<p>Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Moderate</p>	<p>The menu has been approved by a dietitian, however, there is no current food control plan. The food control plan on display expired in August 2021. The food control audit had been completed in January 2021. Corrective actions from the January audit had not been addressed or submitted to ensure that a current food control plan was in place.</p> <p>Food was stored appropriately in the fridges, freezers, and pantry. However, not all food stored in the fridges and freezers was labelled and dated. For example, in the fridge there were several plates of sandwiches unlabelled and four partial packets of meat which had been opened and then rewrapped; there was no labelling as the type of meat or the date it had been opened and</p>	<p>i) There is no current food control plan.</p> <p>ii) Not all food stored in the fridges and freezers is labelled and dated.</p> <p>iii) The kitchen cleaning schedule is not adhered to and does not include small kitchen fridges or fridges in residents' rooms.</p> <p>iv) Monitoring of food temperatures for the evening meal is inconsistent.</p>	<p>i) Ensure that a current food control plan is in place.</p> <p>ii) Ensure that food stored in the fridges and freezers is labelled and dated.</p> <p>iii) Ensure that the kitchen is clean, and the cleaning schedule adhered to.</p> <p>iv) Ensure that the</p>

		<p>rewrapped. Food in the freezer was undated. In the freezer there were food items in a bin with a loose covering of glad wrap and no label as to date and contents. There is no monitoring of small kitchen and residents in room fridges temperatures, labelling and dating and covering of food or cleaning program, many were found to be dirty and smelly.</p> <p>There is a kitchen cleaning schedule in place. However, this schedule is not adhered to. At interview the food manager confirmed that staff sign to indicate they have completed a cleaning task without having done so. There was evidence that some areas and equipment in the kitchen were unclean. These include the microwave, a small fridge, storage bins and containers in the pantry.</p> <p>There is a form for recording the temperature of the meals served to residents. The temperature of the main meal at lunchtime is recorded consistently. However, the temperature of the evening meal is inconsistently recorded.</p>		<p>temperature of food served to residents at mealtimes is checked and recorded.</p> <p>60 days</p>
<p>Criterion 1.4.1.6 Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service</p>	<p>PA Moderate</p>	<p>Personal protective equipment is available when handling hazardous substances for staff, along with hand sanitizer and soap dispensers. However, restocking of PPE is not always completed.</p>	<p>Sluice rooms are not always stocked with PPE for sluicing substances and there are no protective “splash” barriers over the sluices or face shields provided.</p>	<p>i) Ensure that face shields or protective barriers on sluices are provided and used by staff.</p> <p>ii) Ensure that hand sanitizer and soap dispensers are replenished.</p>

providers.				30 days
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA</p> <p>Moderate</p>	<p>Many of the fixtures and fittings are in need of repair. A five-year refurbishment plan has been activated commencing with new wall protection panels and repainting of the corridors in one of the facility. Furniture is not always appropriate to the setting and residents' needs.</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, by the maintenance person and attended to as prioritised by them. Interviews confirmed staff awareness of the processes for maintenance requests and that repairs were not always conducted in a timely manner.</p> <p>There is a system 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 (held as part of the activities program), no fire extinguisher and no functioning hoist. Staff interviews, and documentation evidenced that those staff who drive the van have a current driver's licence.</p> <p>All external decked areas have outdoor seating and shade and can be accessed freely by residents and their visitors, however, not all are suitable for use.</p>	<p>i) There are areas of carpet where there is separation of joints and tears within corridors. In the corridor ramp leading from the two double rooms, there is a bump under the new carpet. Older high-backed vinyl chairs are unstable and have damaged parts and the chairs on the lounge balcony in Rubcor wing are dilapidated and not fit for purpose.</p> <p>ii) Maintenance requests are not always responded to in a timely manner, (e.g. bell call system), cleaning of moss and mould from decking and paths and ensuring outside contractors complete routine maintenance such as clearing/cleaning roof spouting. The outside decks and stairwells in Rubcor wing are open and used by residents and visitors, these do not have adequate safety railings and do not comply with building safety regulations.</p> <p>iii) The van used for resident outings is in a dirty condition, both internally and externally. Seats are torn and shedding foam, the metal steps which staff are required to unload and place by the side door are unstable on a non-flat surface and are difficult to manipulate for staff and for residents to utilise. Consequently, the van is unfit for purpose and is used for only a small number of ambulatory residents or for the maintenance person to pick up equipment or stores. The facility car is also poorly cared for and residents have difficulty accessing the seating due to the low level. Only those few, who are more able, can be taken in it to</p>	<p>i) Ensure that fixtures and fittings are up to standard, routinely monitored, cleaned, and are repaired or replaced in a timely manner.</p> <p>ii) Ensure that environmental hazards are addressed promptly and minimised or closed out.</p> <p>iii) Ensure that vehicles used to transport residents are fit for purpose.</p> <p>iv) Ensure that staff and residents smoke in the designated area, and that maintenance is carried out to remove clumps of cigarette butts from car parks and gardens.</p> <p>90 days</p>



			<p>appointments.</p> <p>iv) Due to staff and residents smoking at various areas within the car park and garden areas, there is an unsightly trail of cigarette butts obvious throughout these areas.</p>	
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA</p> <p>Moderate</p>	<p>The routine maintenance monthly checks ensure that all resident hot water bathroom facilities are within the required temperature range and safe for use by residents.</p> <p>Wall surfaces in bathrooms do not all meet infection control guidelines and are difficult to clean.</p> <p>Oxygen usage by residents and storage of oxygen cylinders does not comply with policy and meet safety regulations.</p>	<p>i) Residents kitchenettes have family/resident facilities to make a hot drink. The water at the hot water dispensers is at boiling point, and they do not have guards to protect inadvertent scalding.</p> <p>ii) There are holes and cracks in many of the bathroom facilities that are allowing water penetration and difficulties to ensure cleaning to prevent infection control issues.</p> <p>iii) When oxygen is being used by residents there are no warning notices posted near the rooms. Spare oxygen cylinders are stored unsecured in corridor cupboards.</p>	<p>i) Ensure that the hot drink water dispensers have guards to prevent injury due to the high water temperature.</p> <p>ii) Ensure wall surfaces in bathrooms meet infection control guidelines.</p> <p>iii) Ensure that notices regarding oxygen usage is posted near rooms and residents having oxygen therapy and ensure all oxygen cylinders are firmly secured in storage.</p> <p>90 days</p>
<p>Criterion 1.4.6.2</p> <p>The methods,</p>	<p>PA</p> <p>Moderate</p>	<p>The laundry staff carry out daily cleaning. However, high surface cleaning and removal of</p>	<p>i) Old and disused equipment stored in the small laundry space taking up room and</p>	<p>i) Ensure that old disused equipment</p>

<p>frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>		<p>disused equipment has not been attended to.</p> <p>Cleaners utilise the sluice rooms to dispose of cleaning water. However, high cleaning and cleaning of expellant fans has not been carried out under routine maintenance.</p>	<p>collecting dust. The commercial dryers have old equipment stored behind them which makes servicing them difficult for the contractor. One of the dryers has had elbows from the ventilation hose removed and the hose put back into the ventilation hole in the outside wall. This hose is now ill fitting and has left gaps for vermin to enter the laundry and also allowing dust from the dryer to escape into the clean side of the laundry causing dust build up and poor ventilation for the staff working there.</p> <p>ii) Sluice rooms all have expellant fans which have not been maintained and cleaned causing a build-up of dirt and dust in the grills. High cleaning in these rooms has not been carried out.</p>	<p>is removed from the laundry and that a repair/replacement is carried out on the dryer ventilation hose. High cleaning in this area should be part of routine maintenance.</p> <p>ii) Ensure that high cleaning in sluice rooms inclusive of expellant fans is carried out as a part of routine maintenance.</p> <p>30 days</p>
<p>Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency</p>	<p>PA Moderate</p>	<p>The facility has a stock of kitchen emergency supply which is routinely rotated. However, emergency food supply is limited.</p> <p>Emergency and civil defence planning guides from 2016 and 2019 are in place.</p> <p>The fire emergency steps beside the van car parking are not well maintained.</p>	<p>i) The amount of food stored, inclusive of kitchen stock, would not meet the requirements for three days' supply of food in an emergency.</p> <p>ii) Emergency and civil defence planning guides have not been kept updated and are generic and not site specific.</p> <p>iii) The fire emergency steps beside the van car parking have a non-slip matting which is covered in moss and mould and require to be part of routine maintenance for cleaning to ensure safe use.</p>	<p>i) Ensure there is sufficient food supply for three days in an emergency situation.</p> <p>ii) Ensure emergency and civil defence planning guides are site specific and updated.</p> <p>iii) Ensure fire exit steps are maintained and</p>

procedures.				non-slip/skid proof.  30 days
<p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p>	<p>PA</p> <p>Moderate</p>	<p>Call bells, including those in the lifts, are routinely tested and monitored by the maintenance person and maintained with battery replacement or by an external contractor when required.</p>	<p>The week prior to the audit it had been noted that the lift call bells were not functioning, and staff had reported in the electronic maintenance log that some resident room call bells were not functioning. Batteries were replaced with no effect and an external contractor visited. The facility was awaiting either repair or replacement for the call bell system.</p>	<p>i) Ensure that correct routine testing and maintenance of the call bell system is maintained, results are reported to management, and that repairs or replacement are actioned on in an urgent manner.</p> <p>ii) Ensure that failures in the call bells system are reported to the DHB and Ministry of Health as required under Section 31 of the health and Disability Safety Act 2001.</p> <p>30 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.