# The Ultimate Care Group Limited - Ultimate Care Aroha

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** The Ultimate Care Group Limited

**Premises audited:** Ultimate Care Aroha

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 27 January 2022 End date: 28 January 2022

**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:** 45

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

## General overview of the audit

The Ultimate Care Group Limited - Ultimate Care Aroha provides rest home (inclusive of secure dementia care) and hospital level care for up to 46 residents. There were 45 residents at that facility on the first day of the audit.

This surveillance audit was conducted against a subset of the relevant Health and Disability Service Standards and the service contract with the district health board.

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

The area requiring improvement at the last certification audit relating to neurological monitoring post falls is now closed.

Areas identified as requiring improvement at this audit are relating to: quality and risk documentation; evaluation of care plans; medication management and environmental safety.

## 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. |

The Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is made available to residents and family on the resident’s admission and at the facility.

Open communication between staff, residents and families is being conducted. There is access to formal interpreting services if required.

Residents, family and the general practitioner’s interviews confirmed that the environment is conducive to communication, including identification of any issues, and that staff are respectful of residents’ needs.

There is a documented complaints management system, and a complaints register is maintained. Complaints are investigated and documented, with corrective actions implemented where required.

## Organisational management

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

Ultimate Care Group is the governing body responsible for the services provided at Ultimate Care Aroha.

The service has a current business plan and a quality and risk management plan in place. The facility has implemented the group’s quality and risk management system that supports the provision of clinical care and quality improvement at the facility. The business and quality and risk management plans include the organisation's mission statement and values. Regular reports to the national support office are conducted.

The facility is managed by a facility manager who is supported in their role by a clinical services manager. The facility management team is supported by a regional manager and the group’s support team at head office.

The quality and risk management systems include collection and analysis of quality improvement data which is monitored through the organisation’s reporting systems. An internal audit programme is documented and implemented. Corrective action plans are documented from quality activities when these are identified. Current policies and procedures support service delivery and are reviewed regularly.

Adverse events are documented and where required corrective actions are implemented. Actual and potential risks, including health and safety risks, are identified and mitigated.

Newly recruited staff undertake orientation appropriate to their role. Practising certificates for staff and contractors who require them are validated annually. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review.

A review of rosters and service delivery staff, and resident/family interviews confirmed that there is sufficient staff available.

## Continuum of service delivery

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

Registered nurses assess residents on admission. The initial care plan guides care and service provision during the first three weeks after the 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 medical reviews occur thereafter on a regular basis.

Long term care plans are developed and implemented within the required timeframes, they are individualised and based on an integrated range of clinical information. Residents’ needs, goals and outcomes are identified. Residents and their relatives 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 nurses 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 low risk. |

A current building warrant of fitness is displayed.

There have been no alterations or additions to the facility’s buildings since the last certification audit.

## Restraint minimisation and safe practice

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

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 four residents using restraints 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

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| --- | --- | --- |
| 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)** |
| **Standards** | 0 | 17 | 0 | 3 | 1 | 0 | 0 |
| **Criteria** | 0 | 45 | 0 | 3 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The organisation has a complaints policy and process to ensure that that complaints are managed in line with Rights 10 of the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code). The complaint form is made available to new residents and their families on admission. The complaint forms are available in resident areas in the facility. Resident and family interviews confirmed that they are aware of the complaints process.  The FM is responsible for managing complaints. There is a complaints register which was up to date. Evidence relating to all lodged complaints is held in the complaints folder and on electronic files. Interview with the FM and a review of the complaints indicated that all complaints had been managed in line with the requirements of the Code.  Residents and their families stated that they had been able to raise any issues directly with management and that they had been addressed.  The audit team were advised that there have been no complaints made to external agencies since the last audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Open disclosure policy and processes ensure open disclosure is practiced when this is required. The patient information folder provided to patients and their family on admission includes the organisation’s open disclosure policy.  Adverse events, where a resident has suffered unintended harm while receiving care are documented, investigated and communicated in an open disclosure manner. Completed incident documentation reviewed demonstrated that residents and family are informed if a resident has an incident/accident; a change in health or a change in needs. Family and residents’ interviews confirmed this occurs.  Resident and family interviews confirmed that the facility manager (FM) and clinical services manager (CSM) and staff were approachable and available to discuss queries and issues. Interviews with residents and family identified that management addressed concerns and queries promptly and proactively.  Residents’ meetings inform residents of facility events and activities and provide residents with an opportunity to make suggestions and provide feedback. Minutes from the residents’ meetings showed evidence that a range of subjects and issues are discussed, including but not limited to: activities; food service; laundry; maintenance; facility changes; and resident surveys results. Meeting minutes evidence that issues or concerns raised at the residents’ meetings were responded to by management. Residents and their families are provided with a facility newsletter on regular basis, inclusive of meeting minutes.  There is a policy that provides guidance for staff to ensure that residents who do not use English as their first language are offered interpreting services. The FM interview confirmed there were two residents at the facility requiring interpreting services at the time of the audit. This included the use of staff and family assistance when required. The district health board (DHB) interpreter service would be utilised if required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The facility is part of the Ultimate Care Group (UCG) with the executive management team providing support to the facility. The FM reports to a regional manager, with support from the regional manager and the wider UCG executive management team. Communication between the facility and the UCG executive management occurs regularly, as stated by the FM.  There is an organisation–wide quality and risk management document and the business planning objectives of the facility are documented. Review of the facility’s business plan for 2021-22 was evidenced. The values and mission statement were recorded in the facility’s information pack provided to residents and their families on admission and displayed at the facility.  There is an electronic reporting of events and occupancy into the UCG’s national system by the FM and the CSM, that facilitates review of progress against identified indicators by the executive management team. A range of performance indicators are monitored including but not limited to: admissions and discharges; staffing; compliments and complaints, infections; falls; weight loss and pressure injuries.  The FM has been in this role for four months and has qualifications in management and psychology. The FM is supported by a CSM, who is a registered nurse (RN) and has been in this position for five years. The CSM is supported by a team of RNs.  The facility is certified to provide rest home care (inclusive of dementia care) and hospital level care for up to 46 residents. There were 45 beds occupied at the time of the audit. This included: 14 residents who had been assessed as requiring rest home level care, 14 residents assessed as requiring secure dementia care and 17 residents assessed as requiring hospital level care. Included in the total occupancy numbers were two rest home residents under respite care and one resident requiring secure dementia care under a Ministry of Health mental health and additions contract.  The facility has contracts with the DHB for the provision of: rest home (inclusive of secure dementia) and hospital aged related residential levels of care; residential respite care; and a long term support- chronic health conditions agreement.  The facility had no residents with occupational right agreements. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | There are policies and procedures, and associated implementation systems to ensure that the facility meets accepted good practice and is 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.  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 completed. However, analysis of trends and evaluation of outcomes requires improvement. UCG has made improvements to the electronic system with regard to this.  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.  An annual resident and relative satisfaction survey was completed in 2021, with an average rating of 87% approval. An area requiring corrective action includes the management team. These results have just been collated and a corrective action plan is being developed and actioned.  Ultimate Care Aroha has the FM as the health and safety officer who is supported by the regional manager.  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 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.  Hazards are identified on hazard identification forms. The hazard register is relevant to the service and has been regularly reviewed and updated. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The management team are aware of situations which are required to be reported to statutory authorities, including: unexpected deaths; police involvement; sentinel events; infectious disease outbreaks and changes in key management roles. These are reported to the appropriate authority via the UCG support office staff. Notifications to HealthCERT under Section 31 were noted for the change in FM. A potential respiratory outbreak was reported to Public Health and the DHB in August 2021.  Staff interviewed understood the adverse event reporting process and their obligation to document all untoward events. A review of documentation confirmed that staff document adverse, unplanned or untoward events on accident/incident forms which are signed off by the CSM.  Staff training records reviewed confirmed that staff receive education at orientation and as part of the ongoing training programme on accident/incident reporting processes.  Accident/incident reports reviewed at audit evidenced that where appropriate the resident’s family had been notified, an assessment had been conducted and observations completed. Family and resident interviews confirmed that family are notified where the resident has had an accident/incident or a change in health status. A sample of recorded incidents/accidents evidenced they were predominantly falls and wounds. The events demonstrated that assessments and action plans had been documented for each event. Accident/incidents are graphed, trends analysed and fed back to staff at meetings. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position are documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; police vetting; identification verification; a position specific job description; a signed employment agreement and where required, a current work visa.  Professional qualifications are validated and there are systems in place to ensure that annual practising certificates and practitioners’ certificates are current. Current certificates were evidenced for all staff and contractors that required them.  An orientation/induction programme is available that covers the essential components of the services provided. Care givers (CG) and domestic staff interviewed stated that they are buddied with an experienced staff member until they demonstrate competency on specific tasks.  The organisation has a documented annual education and training module/schedule that includes topics relevant to all services and levels of care provided.  The CSM and four RNs have completed interRAI assessments training and competencies. Care staff complete annual competencies and comprehension, for example: moving and handling; hoist use; hand washing; and medication management.  Education session attendance records evidenced that ongoing education is provided relevant to the services delivered. Interviews and training records reviewed confirmed that all staff, including RNs undertake at least eight hours of relevant education and training hours per annum. An annual appraisal schedule is in place. Staff files reviewed evidenced that staff employed for greater that one year had completed a current performance appraisal. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The organisation’s allocation of staff and duty roster policy requires a base roster be set according to the needs of residents, taking into account dependency levels.  Staff rosters are developed and reviewed to accommodate anticipated workloads, identified numbers of residents to ensure safe staffing levels within the facility are sufficient to meet the needs of residents’ acuity and the minimum requirements of the DHB contract, stated by the FM and CSM.  There are sufficient RNs and CG available to safely maintain the rosters for the provision of care to accommodate increases in workloads and acuity of residents.  In addition to the CSM who is on duty on the morning shifts from Monday to Friday, there is at least one RN on each morning, afternoon and night duty, seven days per week. In addition, there are five CGs on full morning shifts plus a CG on a seven hour shift; five CGs on full afternoon shifts plus a CG on a seven hour shift, and two CGs on each night shift at the facility.  Both the FM and CSM are on call after hours, and UCG have a 504 telephone clinical RN on call after hours for the RN on duty to refer to.  Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy and the requirements of the contract.  Family and resident interviews stated that staffing is adequate to meet the residents’ needs. Staff interviews confirmed that they are able to complete their scheduled tasks and resident cares over their shift. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | A current medication management policy identifies all aspects of medicine management in line with relevant legislation and guidelines.  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. Residents’ allergies and sensitivities were documented on the electronic medication chart and in the resident’s electronic record.  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.  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 daily, however the temperature of the medication room is not monitored.  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.  The RNs 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.  Current medication competencies were evident in staff files reviewed.  There were no residents self-administering medication on the day of the audit. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The kitchen manager is responsible for the food services. The food service is in line with recognised nutritional guidelines for older people. All meals are prepared on site and served in the dining rooms or in the residents’ rooms if requested. The seasonal menu has been reviewed by a dietitian, with the summer menu implemented at the time of audit. The food control plan is current. Food management training and certificates for the chef, cook and kitchen staff were sighted.  Food temperatures are monitored and recorded. The kitchen staff have relevant food hygiene and infection control training. The kitchen was observed to be clean, and the cleaning schedules sighted.  A nutritional assessment is undertaken by the RN for each resident on their admission, to identify the residents’ dietary requirements and preferences. The nutritional profile is communicated to the kitchen staff and updated when a resident’s dietary needs change. Diets are modified as needed and the chef at interview confirmed awareness of the dietary needs, likes and dislikes of residents. These are accommodated in daily meal planning.  Residents were observed to be given sufficient time to eat their meal. There were sufficient staff to ensure appropriate assistance was available. Residents and families interviewed stated that they were satisfied with the meals provided.  Snacks and drinks are always available to residents in the dementia unit.  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 and freezers. Temperatures of fridges and the freezer are monitored and recorded daily. Dry food supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Long term care plans are completed by the RN and based on assessed needs, desired outcomes, and goals of residents. Care planning includes specific interventions for long-term and acute problems.  Interventions are reviewed and updated if there are changes in the health status of a resident.  The GP documentation and records reviewed were current. A physiotherapist visits the facility weekly and reviews residents referred by the CSM or RNs. Contact with family was verified in the resident’s records. Interviews with residents and their families confirmed that care and treatment met residents’ needs.  There was evidence of wound care products available at the facility. The review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were taken and recorded where this was required. Where wounds required additional specialist input, this was initiated.  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. Family communication is recorded in the residents’ files. The nursing progress notes are recorded and maintained.  Monthly observations such as weight and blood pressure were completed and were up to date. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The residents’ activities programme is implemented by a diversional therapist who is assisted two days a week by an activities assistant. Activities for the residents are provided six days a week, Monday to Friday, 9.30 am to 3.30 pm and from 10.00 am to 3.00 pm on Saturday. The activities programme is displayed on the residents’ noticeboards. The activities programme provides variety in the content and includes a range of activities which incorporate education, leisure, cultural and community events. Regular van outings into the community are arranged. Church services are held monthly.  The residents’ activities assessments are completed within three weeks of the residents’ admission to the facility in conjunction with the RN. Information on residents’ interests, family and previous occupations is gathered during the interview with the resident and their family and documented. Outcomes against goals are recorded when the formal review of the care plans occur. However, the formal reviews of the care plans are not consistently carried out within the required timeframe (refer to 1.3.3.3).  Residents in the dementia unit have 24-hour behaviour management plans to assist staff in the identification and de-escalation of behaviours that may be challenging. The diversional therapist ensures the implementation of activities in the dementia unit is occurring.  There is evidence of resident and family/whānau participation. Regular resident meetings are held and include discussion around activities. The residents and their families reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging and enjoying a variety of activities. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it is reported to the RN.  LTCPs are evaluated if there is a change in the resident’s condition and inteRAI assessments are completed every six months. However, the six-monthly evaluation of the LTCPs with information from the interRAI assessment does not consistently occur within the required timeframes (refer to 1.3.3.3).  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. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The building warrant of fitness is current and displayed at the facility, with an expiry date of 30 April 2022.  There have been no alterations to the facility since the previous audit,  Appropriate systems are in place to ensure the environment is hazard free, and independence is promoted. However, improvements are required around privacy, personal protective equipment and chemical storage on the cleaner’s trolley. |
| 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 (IPC) audits are completed. Infection data is collated monthly and is submitted to the UCG 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, clinical and staff meetings. The UCG reflection report is displayed on the staff noticeboard.  Short term care plans are developed for infections and reviewed and signed off when the infection resolves.  Interview with the CSM confirmed there has been one outbreak (respiratory) since the previous audit. Documentation reviewed and interview with the GP confirmed that this had been managed well and resolved within two weeks. |
| 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, four residents were using restraints, bedrails, and/or lap belts. 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. Staff receive restraint minimisation training at orientation and as part of the UCG training programme which includes annual competency assessments.  Equipment including low-low beds and sensor mats is available to minimise the use of restraint. Review of restraint and enabler use is completed and discussed at all quality, clinical and staff meetings. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint approval process is described in the restraint minimisation policy. The restraint coordinator is the CSM with 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. The CSM explained the process for determining approval, for recording, monitoring, and evaluating any restraints or enablers used. The GP at interview confirmed involvement with the restraint approval process. Family/whanau approval is gained should any resident be unable to do so. Any impact on family is also considered. This was evidenced by documentation and files viewed. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | 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. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Restraint and enablers are used to maintain resident safety and only as a last resort. The restraint coordinator discusses alternatives with the resident, family/whanau, GP, and staff. Documentation includes the method approved, when it should be applied, frequency of monitoring 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.  A restraint register is maintained and reviewed by the restraint coordinator who shares the information with staff at the quality, clinical and staff meetings. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | All restraints are reviewed and evaluated as per the UCG policy and 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. Evaluations are discussed at the quality, clinical and staff meetings. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Click here to enter text |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Corrective actions are raised from quality improvement data inclusive of internal audits. However, the analysis of trends and evaluation of outcomes from corrective actions are not completed and relayed to staff. | (i) Outcomes for corrective actions are not documented, inclusive of evaluations prior to sign off.  (ii) Quality, health and safety, and staff meetings do not fully inform staff of evaluations and outcomes for corrective actions raised. | (i) Outcomes and evaluations of corrective actions should be documented.  (ii)) Quality, health and safety, and staff meetings should clearly outline corrective actions and improvements.  90 days |
| Criterion 1.3.12.1  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. | PA Moderate | The RN oversees the use of all PRN medications. However, documentation of the effectiveness of the medication given does not always occur. In six out of ten medication charts reviewed, effectiveness was not recorded on the electronic medication system or in the progress notes for all PRN medication administered  The temperature monitoring of the medication fridge occurs daily, however there is no monitoring of the temperature of the medication room. | i. The effectiveness of PRN medications administered is not consistently documented.  ii. The temperature of the medication rooms is not recorded as per UCG policy. | i. Ensure that the effectiveness of all PRN medication administered is documented.  ii. Ensure that the temperature of the medication rooms is monitored and recorded in accordance with UCG policy.  90 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | LTCPs are evaluated if there is a change in the resident’s condition. However, in two out of five files reviewed, the formal six-monthly evaluation of the care plan was overdue by several months. The service has developed a quality improvement plan to rectify this issue, but this had not been implemented on the day of audit. | LTCPs are not consistently evaluated within the required timeframe. | Ensure that all LTCPs are evaluated within the required timeframe.  90 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. Efforts are made to ensure the environment is hazard free, that residents are safe, and independence is promoted. However, improvements are required around privacy, personal protective equipment and chemical storage on the cleaner’s trolley. | i) There are no privacy signs on the dementia unit toilets and showers and also on two showers in the hospital wing.  ii) The sluices and laundry tubs and hoses did not give staff protection from splash back, with either a splash guard or face shield provided.  iii) The cleaner’s trolley had chemicals stored in an unsafe manner. | i) Ensure privacy signs are installed for all toilets and showers  ii) Ensure that staff have adequate protection when handling soiled items  iii) Ensure that chemicals are stored securely on the cleaner’s trolley.  60 days |

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

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

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

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

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End of the report.