

The Ultimate Care Group Limited - Ultimate Care Cambridge Oakdale

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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	The Ultimate Care Group Limited
Premises audited:	Ultimate Care Cambridge Oakdale
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: 18 June 2018 End date: 19 June 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	42



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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 Cambridge Oakdale provides residential care for up to 47 residents who require hospital, rest home and dementia level care. On the day of the audit there were 42 residents. The facility is operated by The Ultimate Care Group Limited.

This surveillance audit was conducted against aspects of 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, families, management, staff and a general practitioner.

The areas requiring improvement from the previous certification audit relating to reporting of quality data to staff; orientation of staff; on-going education and restraint competency assessments; storage of archived documents; resident documentation; the management of weight loss; access to the van for residents who have limited mobility; and aspects of medicine management have been addressed. There are no improvements required from this audit.

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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Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to formal interpreter services if required.

The facility manager is responsible for the management of complaints and a complaints register is maintained. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The Ultimate Care Group Limited is the governing body and is responsible for the service provided. A strategic business plan and quality and risk management systems are fully implemented at Ultimate Care Cambridge Oakdale. Systems are in place for monitoring the service, including regular reporting by the facility manager and clinical services manager to the national support office.

The facility is managed by a facility manager who is new to the position. The facility manager has experience in the aged care sector and has worked at the facility for eight years.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on incident/accident forms. Incident/accident forms and meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address any areas that require improvement. Quality, health and safety, registered nurses (RNs), staff and residents' meetings are held on a regular basis. The risk register evidenced review and updating of risks and the addition of new risks.

Human resources processes are followed. Staff have the required qualifications. An in-service education programme is provided, and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on an electronic rostering tool that calculates staffing requirements based on the needs of residents. Registered nurses are rostered on duty at all times. The facility manager and clinical services manager are rostered on call after hours.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The processes for assessment, planning, provision of care, evaluation, review and exit are provided within time frames that safely meet the needs of the residents and contractual requirements.

All residents have interRAI assessments completed and individualised care plans related to this programme. When there are changes to the resident's needs a short-term plan is developed and integrated into a long-term plan, as needed. All care plans are evaluated at least six monthly.

The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a four-week rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness is displayed. There have been no structural alterations since the previous 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.
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The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There was one resident using a restraint at the time of audit. No residents were using enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, in a timely manner.

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	0	0	0	0
Criteria	0	40	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The information is provided to residents and families on admission and there is complaints information and forms available throughout the facility. All complaints have been entered into the complaints register. Two complaints were reviewed and actions taken, through to an agreed resolution, were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible.</p> <p>The facility manager is responsible for complaint management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>The regional operations manager reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous certification audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	<p>FA</p>	<p>Residents and families stated they are kept well informed about any changes to their own or their relative's status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by</p>

effectively with consumers and provide an environment conducive to effective communication.		policies and procedures that meet the requirements of the Code. Interpreter services can be accessed via the local DHB if required.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The business and strategic plans are reviewed annually and include the purpose, values, scope, direction and goals and objectives of the organisation. An organisational flowchart shows the positions within the organisation. Monthly reports are generated electronically and sent to the national support office. Reports include but are not limited to financial performance, occupancy, staffing and any risks.</p> <p>The facility manager (FM) is new to the position and started on the day of the audit. The FM has experience working in the aged care sector and has worked in the facility for eight years, four years as a caregiver and four years as an activities coordinator. The FM has almost completed the diversional therapy programme and is enrolled to undertake a diploma in business management. The FM is currently being orientated to their position by the regional operations manager who stated they will be at the facility for at least three weeks. The FM is also supported by the clinical services manager (CSM) who has been in their position since April 2018. The CSM has prior experience in aged care as a registered nurse working on the floor and as an acting CSM for another organisation. The CSM is responsible for oversight of the clinical service in the facility.</p> <p>Ultimate Care Cambridge Oakdale is certified to provide 47 hospital, rest home and dementia level care beds. All the hospital and rest home beds have been approved as dual-purpose beds and there are 16 dedicated dementia beds. On the day of audit there were 42 residents - 13 hospital including one resident under the age of 65 years, 16 rest home residents and 13 dementia level care residents.</p> <p>Ultimate Care Cambridge Oakdale has contracts with the DHB for aged related residential care services and long term chronic health conditions.</p> <p>The regional operations manager advised HealthCERT has been notified of the change of FM and CSM since the previous certification audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	FA	<p>The organisation has a comprehensive quality and risk management system that guides the quality programme and includes principles and quality targets for 2018. Two projects have been identified for 2018 relating to the management of weight and pain and information is updated electronically two monthly.</p> <p>Quality data for incident/accidents, satisfaction surveys, internal audits, infections, pressure injuries and medication errors is being collected, collated and comprehensively analysed to identify trends. Corrective actions are developed and implemented with monitoring to make sure corrective actions have been effective. Quality, RN, staff, health and</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>safety and resident meeting minutes reviewed evidenced regular reporting and review of data including any trends. Monthly reports, including graphs, are provided by the national support office. The CSM demonstrated sound knowledge relating to quality and risk management. Staff confirmed they are kept fully informed and discuss quality data at their meetings including trends and what corrective actions have been put in place.</p> <p>Resident and family satisfaction surveys are completed yearly. The 2017 survey showed residents and families are satisfied or very satisfied with the service provided.</p> <p>Policies and procedures are fully embedded at Ultimate Care Cambridge Oakdale. They are relevant to the scope and complexity of the service, reflected current accepted good practice and referenced legislative requirements and refer to interRAI. Policies and procedures have been reviewed by the clinical advisory panel (CAP) and are current. New / reviewed policies are available for staff to read in the nurses' station and they are required to sign off these once read. Staff interviewed confirmed this. Staff also confirmed the policies and procedures provide appropriate guidance for service delivery.</p> <p>Actual and potential risks are identified and documented. The risk register includes but is not limited to clinical, environment, staffing and financial risks. A risk matrix is used to rate the level of risk. The FM, who is the health and safety representative, is responsible for the management of hazards, including putting in place appropriate controls to eliminate or minimise all hazards on site. Interview of the FM confirmed this. Hazards are communicated to staff and residents as appropriate. The FM demonstrated a sound understanding of health and safety requirements. Staff confirmed they understood and implemented documented hazard identification processes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Adverse, unplanned or untoward events are documented by staff on incident/accident forms and are reviewed by the RN on duty and the CSM. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. Adverse event data is collected and reported to the national support office where it is analysed and benchmarked with the other facilities within the organisation. A report is generated and provided to the facility and the CSM is responsible for interpreting the data and reporting back to staff.</p> <p>Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Staff are aware of essential notification responsibilities. The regional operations manager stated there has been one Section 31 notified for a pressure injury made to HealthCERT since the last certification audit and another pressure injury was notified on the day of the audit. The regional operations manager reported there have been no other notifications made to external agencies.</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>Policies and procedures relating to human resources management are based on relevant legislation and good employment practice. Staff files reviewed include job descriptions which outline accountabilities, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.</p> <p>New staff are required to complete the orientation programme prior to their commencement of care to residents, including specific components depending on the position description. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers the essential components of the service provided. Staff reported the orientation process prepared them well for their role.</p> <p>The education programme is the responsibility of the CSM. Documentation evidenced in-service education is provided at least monthly and during the monthly staff meetings where the RNs are expected to lead education sessions. External educators are sourced, and staff have the opportunity to attend sessions externally and are expected to share the information with the rest of the staff. Individual certificates of training, attendance and competencies including restraint and medication were evidenced on staff files. Five RNs, including the CSM are interRAI trained and have current competencies. Current first aid certificates were sighted on the RNs' files.</p> <p>A New Zealand Qualification Authority education programme is available for staff who have not already completed the programme. All staff working in the dementia unit have completed or have started the dementia specific modules.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery. A documented and implemented process determines staffing levels and skill mixes to provide safe care to residents. Staffing levels are adjusted to meet the changing needs of residents, resident acuity including interRAI, occupancy and the environment. The Ultimate Care Group electronic rostering tool is based on the handbook indicators for safe aged care and dementia care. Staff are also consulted about any changes in workloads. The FM and CSM work full time Monday to Friday. Registered nurse cover is provided seven days a week over the 24-hour period. The FM and CSM are on call after hours. The roster showed at least one staff member per shift has a current first aid certificate. There are dedicated cleaning and laundry staff. An activities coordinator provides activities currently in the rest home, hospital area and the dementia unit. Staff in the dementia unit are also responsible for providing activities and volunteers come into the facility and provide activities. The FM reported there has been a good response to advertising for another activities person including two diversional therapists. The CSM reported they are about to</p>

		<p>employ another two RNs once all documentation required has been received.</p> <p>Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and family reported there was enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover is provided.</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>	FA	<p>Archived records are held securely on site in a shed at the back of the facility. The shed is water proof and files are stored in boxes on shelves and off the floor. Records are readily retrievable using a cataloguing system on each box. No personal or private resident information was observed on public display during the audit.</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>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and</p>

		<p>discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart.</p> <p>There were no residents who were self-administering medications at the time of audit. There is an implemented process for comprehensive analysis of any medication errors.</p> <p>The previous audit identified an area for improvement to ensure that all medication charts had reason for use of prescribed pro re nata (PRN) medications and that all prescribed medications provided to rest home level care residents were provided in individually identified and labelled medication bottles. The corrective action is now addressed with the implementation of an electronic medication management system in May 2017. At time of audit an observation of a medication round also demonstrated and confirmed safe medication practice.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by one of two cooks, supported by kitchen staff, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The facility is registered with the Ministry of Primary Industries (MPI) and has opted to use the New Zealand Aged Care Association (NZACA) food plan template. The facility is awaiting the arrival of the food plan and intends to individualise the template to their service choosing also to be audited in the future by their preferred provider. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook interviewed has undertaken a safe food handling qualification.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals was verified by residents and family interviews and in residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and</p>	FA	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident. The 'house doctor' interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a very good standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in</p>

appropriate services in order to meet their assessed needs and desired outcomes.		accordance with the residents' needs.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is currently provided by two activities co-ordinators. The activities staff support residents in the dementia unit from Monday to Friday 8.30 am to 12.30 pm and Monday to Friday in the rest home/hospital areas from 8.30am to 3.30pm. The residents are also supported by regular volunteers including music therapy which occurs in the dementia unit on a Friday afternoon from 2 pm to 3 pm. The facility is currently interviewing for an activities co-ordinator in the rest home/hospital area. The new facility manager, who has almost completed her diversional therapy papers, will continue to provide oversight to the activity programme.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Several residents are independent and encouraged to connect and interact with the community while other residents are supported by the staff and groups in the community to partake in regular community activities and groups. Residents and families/whanau are involved in evaluating and improving the programme through residents' meetings and day to day discussions. Residents interviewed confirmed they find the programme interactive and fun.</p> <p>The previous audit identified an area for improvement to ensure that all residents including residents with reduced/limited mobility were able to access the facility van thus access events in the community. The corrective action is now address with records available to demonstrate that the residents are supported by the ongoing use of the facility's car (currently away at another facility for three weeks), facility van and the regular hire of a second mobility van. Residents interviewed stated that they enjoy their outings and the ongoing access to their community.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Specific activities are offered at times when residents are most physically active and/or restless and evidence of these activities were sighted in the resident's care plans supporting challenging behaviours over a 24-hour period. Activities can include one to one, distraction, going for walks, reminiscence and activities of daily living.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service</p>	FA	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or</p>

<p>delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care and there is evidence of working documents throughout the fifteen residents' files reviewed. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, skin tears, falls and challenging behaviours. When necessary, and for unresolved problems, long term care plans are added to and updated. Families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A building warrant of fitness is displayed at the front entrance that expires on the 17 June 2019. There have been no structural alterations since the previous certification audit.</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>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infections, respiratory tract infections, skin, wound, eye, gastroenteritis and other infections. The IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers.</p> <p>The facility has had a total of 24 infections since January 2017. Two residents have recently been commenced on prophylactic antibiotics and this was highlighted in GP and family discussions and long-term care planning to reduce and minimise the risk of infection due to co-morbidities. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Thirty four of 39 residents at the time and eight staff in April of 2018 consented to the flu vaccine with five residents actively declining.</p> <p>Data is benchmarked internally within the group. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>A summary report for a recent gastrointestinal infection outbreak on the 29th December 2017 through to 11th January 2018 with a total of 20 residents and 13 staff effected was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional</p>

		staff education implemented.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint minimisation policy has a section on enablers that includes a definition, assessment and evaluation. The restraint coordinator, who is a RN, reported the aim is to have no restraint. Up until recently, there was no resident using restraint. One resident is currently using bedrails as a restraint and there are no residents using an enabler. Staff interviewed demonstrated good knowledge of the difference between a restraint and an enabler and the process should a resident request an enabler. Staff have received on-going education relating to challenging behaviours, enablers and restraint.

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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.