

The Ultimate Care Group Limited - Ultimate Care Oakland

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	The Ultimate Care Group Limited
Premises audited:	Ultimate Care Oakland
Services audited:	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 5 December 2019 End date: 6 December 2019
Proposed changes to current services (if any):	The conversion of two bedrooms into a lounge/dining area in the rest home wing, reducing certified beds from 92 to 90.
Total beds occupied across all premises included in the audit on the first day of the audit:	74



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

The Ultimate Care Group Limited - Ultimate Care Oakland is certified to provide care for 92 residents, however following refurbishment has converted two bedrooms to a lounge/dining room and now can provide care for up to 90 residents requiring rest home and hospital level care. There were 74 residents at the facility on the first day of the audit.

This surveillance audit was conducted against the relevant Health and Disability Service Standards and the service contract with the Bay of Plenty District Health Board.

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

There were no areas requiring improvement at the previous certification audit.

There are six areas identified as requiring improvement at this audit relating to: communication; complaints; quality improvement documentation; incident/accident management; long-term care planning and food service.

Consumer rights

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

Residents, family and the nurse practitioner's interviews confirmed that staff are respectful of residents' needs. There is access to interpreting services if 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.
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The Ultimate Care Group Limited is the governing body responsible for the services provided at Ultimate Care Oakland. The mission and values of the organisation are documented and communicated to all concerned.

The facility is managed by an appropriately qualified and experienced facility manager. A clinical services manager provides oversight of clinical service provision and is supported by a team of registered nurses. The management team is supported by a regional manager.

The facility has implemented the Ultimate Care Group Limited's quality and risk management system that supports the provision of clinical care and quality improvement. Policies and procedures are reviewed and current. Regular on-line reporting of activity to the national support office allows for the monitoring of service delivery.

Quality and risk performance is monitored through the organisation's reporting systems. An internal audit programme is documented and implemented. Corrective action plans are documented from quality activities, with evidence of resolution of issues when these are identified.

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

Ultimate Care Group Limited human resource policies and procedures are implemented. Newly recruited staff undertake orientation appropriate to their role. Practising certificates for staff and contractors who require them are validated annually. An annual training programme is implemented.

A review of rosters and service delivery staff, resident and family interviews confirmed that there is adequate 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 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 to the facility.

The interRAI assessment process is used to identify residents' needs and these are completed within the required timeframes. The contracted nurse practitioner completes a medical assessment on the resident's admission and reviews occur thereafter on a regular basis.

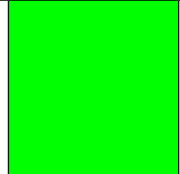
Short-term care plans are in place to manage short-term issues or problems as they arise. Residents' files reviewed demonstrated their needs, goals and outcomes are identified and reviewed. Interviews confirmed residents and their families are informed and involved in the care planning and evaluation of care. Handovers between shifts guide continuity of care and team work is encouraged.

The activity programme is managed by an activity coordinator and an activities assistant. The programme provides residents with a variety of individual and group activities. Family are able to participate in the activities programme.

Medicine management occurs according to policies and procedures and in alignment with legislative requirements and is implemented using an electronic system. Medications are administered by registered nurses, enrolled nurses and senior care givers. Medicine management competencies reviewed for staff who administer medicines, are current.

Kitchen staff have food safety qualifications. The food service has a food control plan that is current and displayed.

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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The facility has a current building warrant of fitness. A refurbishment has occurred to convert two rooms into a lounge dining area and during this process, no structural changes have been made since the last audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation implements policies and procedures that support the minimisation of restraint. There was one enabler, and one restraint in use at the time of this audit. Staff interviews confirmed understanding of the restraint and enabler processes. When enablers are used, enabler use is voluntary. Restraint education is provided to staff at orientation and annually thereafter. A restraint register is maintained.

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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Infection prevention and control surveillance is undertaken, analysed and trended. Results are reported to staff. Surveillance records showed evidence of follow-up of infection when required. The infection surveillance programme is reviewed annually. Staff interviewed demonstrated current knowledge and practice of infection control principles.

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	10	0	6	0	0	0
Criteria	0	33	0	6	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>	PA Low	<p>The organisation has a complaints policy and process to ensure that complaints are managed in line with Right 10 of the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code.) A copy of the complaints process and a complaints form is included in the pack of information provided to residents and their families on admission. The complaints process and forms are also available in resident areas within the facility.</p> <p>Residents’ and family interviews confirmed awareness of the complaints process and their right to advocacy services.</p> <p>The facility manager is responsible for complaints management. Complaints reviewed demonstrated that complaints are responded to within the required timelines, investigated, corrective actions implemented and closed out when resolved, however not aspects of the complaints process were completed consistently. There were a number of complaints about food and the complaints register was not maintained (refer to 1.3.13.5).</p> <p>There had been no complaints to external agencies since the previous audit.</p>
<p>Standard 1.1.9: Communication</p>	PA Low	<p>The organisation has an open disclosure policy that promotes a transparent, consistent approach to full and open disclosure where there is an instance of actual or potential adverse event and or harm during a resident’s care. Completed incident/accident forms, residents’ records and resident and family interviews demonstrated that family</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>are consistently informed whenever the resident has an incident/accident; a change in health status or a change in needs. Family contact is recorded on incident/accident forms and in residents' files.</p> <p>Staff, residents and family interviews confirmed that family are included where appropriate in resident care planning meetings.</p> <p>Monthly resident meetings inform residents of events and activities. Meetings are advertised in a schedule posted in key resident areas in the facility. Family are welcome to attend meetings, if they wish. Meeting minutes are posted on the resident notice board for residents to review. Minutes sighted demonstrate that topics discussed include for example: staffing; food; clinical care; and general business items. The facility has a Facebook page, open to residents and family members only, where activities and events are advertised and posted. Facility manager interview advised that residents consented to the use of social media. Family also receive emails updating them on facility activities such as the facility Christmas party.</p> <p>The facility manager advised that there was an 'open door policy' for residents and family. This was observed at audit. Resident and family stated that they are kept fully informed, communication is regular and appropriate, staff are approachable, the facility manager is readily available to discuss matters and that any queries are responded to promptly. The current facility activities programme is posted on the notice board. Feedback documented in resident meetings, complaints and resident interviews identified a level of dissatisfaction with food, which the facility manager has addressed through meetings with residents. However, the current menu is not posted.</p> <p>There is policy to ensure that information is supplied in a way that is appropriate, for the residents and/or their families, takes account of specific language requirements and any disabilities. Policy requires that where required, interpreters and cultural representatives/advocacy services are accessed to ensure information is understood. Contact details for interpreter services are posted on the facility information board. Interview with the facility manager confirmed that interpreter services are available, through the Bay of Plenty District Health Board to the facility. The facility manager stated that there were no residents at the facility requiring interpreting services at the time of the audit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The quality and risk management document outlines the mission and values as well as detailing the business planning objectives of the organisation. The values and mission are communicated to all concerned through the facility's information pack provided to residents and their families on admission and on the wall of the facility. Staff receive this information at orientation.</p> <p>Ultimate Care Oakland (Oakland) is part of Ultimate Care Group Limited (UCG). In the month prior to the audit, UCG had implemented an organisational restructure and Oakland's facility manager now reports to a regional manager, who is responsible for both regional quality and operational matters. The facility manager reported that regular contact with the regional manager occurs.</p> <p>The facility provides ongoing electronic reporting of events and occupancy that provide UCG executive</p>

		<p>management team with progress against identified indicators. A sample of monthly reports to the regional manager and the national office showed information that monitors the service's performance including but not limited to: financial performance; occupancy; staffing updates as well as key indicators such as: complaints and infections. Benchmarking against other UCG facilities occurs at a national level.</p> <p>The service is managed by a facility manager who has been in the role for just under two years and has ten years' experience in aged residential care management as well as previous experience in a district health board (DHB) in information technology. The facility manager is supported by a clinical services manager (CSM) who has been in the role for just over seven months and has worked in aged residential care as a registered nurse (RN) for eight years, including two years as a clinical team leader. The CSM is supported by a team of nine RNs, two enrolled nurse and the regional manager.</p> <p>The facility is certified to provide rest home and hospital level care services for up to 92 residents. A refurbishment programme was in place. Two rooms had been decommissioned and converted into a lounge/dining area reducing beds from 92 to 90. There are 15 rooms awaiting refurbishment. This has resulted in 75 rooms being available for use at the time of audit, these beds included 68 dual purpose beds; and 7 rest home beds. There were 74 beds occupied on the first day of the audit. Occupancy included: 36 residents requiring rest home level care and 38 residents requiring hospital level care. These numbers included: 4 young persons with physical disabilities (YPD) : 3 whom were assessed as requiring hospital level care; and 1 assessed at rest home level care. In addition to the YPD residents, occupancy also included two residents, under the age of 65 years, who were under the long-term chronic health conditions contract and assessed at hospital level of care'. The facility holds contracts with the Bay of Plenty District Health Board for aged related residential care contract, long term chronic health conditions; respite care; young people with physical disabilities; young people with intellectual disabilities, and home-based support.</p> <p>The facility had no residents with occupational right agreements.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>PA Low</p>	<p>The documented and implemented UCG quality and risk management system is accessed by staff to guide service delivery, improve quality, monitor compliance and manage risks.</p> <p>Policies and procedures align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. Policies and procedures include current wound management that require use of recognised best practice and pressure injury prevention management. The Ultimate Care Group Limited management group reviews all policies with input from relevant personnel. Staff have electronic access to policies and procedures via UCGs internal network. New and revised policies are presented to staff and staff interviews confirmed that they are made aware of new and updated policies.</p> <p>Quality improvement, risk management and clinical indicators are discussed at monthly staff and quality meetings. Staff interviews confirmed that they are kept informed of quality activities through meetings. Quality data and corrective actions are discussed at staff meetings. However, some meeting minutes do not reflect all areas of quality</p>

<p>principles.</p>		<p>improvement information required.</p> <p>Residents and family are notified of facility changes and events through residents' meetings. Interviews with residents and family confirmed that residents are satisfied that the service meets their individual needs and that they are provided with choices. Interview with younger persons with disabilities and observation confirmed that they are satisfied, that they have choices and are able to make decisions in regard to activities, equipment/aids, furnishings etc, contribute to and have input into services through meetings and one-on-one discussions with staff and the facility manager.</p> <p>Satisfaction surveys for residents and family are completed as part of the annual internal audit programme. The results of the recently collated overarching UCG satisfaction survey were sighted. However, results specific to Oakland are not yet available.</p> <p>There was evidence that corrective actions are developed for quality improvement activities and opportunities for improvement are implemented.</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>PA Low</p>	<p>The facility manager is aware of situations which require reporting 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 UCG support office staff. Since the previous audit the appointment of the facility manager and two separate appointments of clinical services managers, had been notified to the Ministry of Health.</p> <p>Staff interviewed understood the adverse event reporting process and their obligation to document all untoward events. A review of documentation confirmed that staff document adverse, unplanned or untoward events on incident/accident forms, which are signed off by the facility manager or the CSM. Information is also entered on an electronic data base of incidents/accidents.</p> <p>Staff training records reviewed confirmed that staff receive education at orientation and in the annual training programme on incident/accident reporting processes.</p> <p>Incident/accident reports reviewed at audit evidenced that where a resident had sustained an injury or a fall for example; the RN had undertaken a physical assessment of the resident, such as a skin assessment, a falls assessment, blood pressure and neurological assessment where appropriate. However, neurological observations did not reflect best practice.</p> <p>Corrective actions arising from incidents/accidents were implemented. All incidents/accidents reviewed demonstrated that the resident's family had been notified. This was confirmed in family and resident interviews.</p> <p>Information gathered is shared at monthly meetings with incidents/accidents graphed and trends analysed.</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 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 demonstrate that recruitment processes for all staff include: reference checks; police vetting; a position specific job description; a signed employment agreement and where required a valid work visa.</p> <p>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.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. Care givers are buddied with an experienced staff member until they demonstrate competency on specific tasks, for example: resident cares; hand hygiene; moving and handling.</p> <p>The CSM and six of nine RNs have completed interRAI assessments training and competencies. Care staff complete annual competencies.</p> <p>The organisation has a documented annual education and training module/schedule, that includes topics relevant to all services and levels of care provided. Education session attendance records evidence that ongoing education is provided relevant to the services delivered. Interviews and training records sampled, confirmed that staff undertake at least eight hours of relevant education per annum. Registered nurse interviews confirmed that they have access to and attend external training through the DHB such as infection control lectures and a wound management conference. An annual appraisal schedule is in place. All staff files reviewed evidenced that staff employed for greater than one year have completed a current performance appraisal. Staff who have been employed for less than one year had completed an orientation review after three months.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The organisation's allocation of staff and duty roster policy requires; a base roster to be set according to the needs of the resident groups, individuals and numbers. Staff hours are required to be set to ensure that they are sufficient to provide safe care in a timely manner, taking into account such things as dependency levels and time required to provide care. A base roster is developed and reviewed to accommodate anticipated workloads, to identify numbers of residents to ensure safe staffing levels, are met within the facility and are sufficient to meet the needs of residents' acuity and the minimum requirements of the DHB contract.</p> <p>There are 78 staff, including: the management team; administration; clinical staff; activities staff; and household staff. Household staff include cleaners, laundry assistants and kitchen staff who provide services seven days a week. There are nine RNs, two enrolled nurses and forty-two care givers available to maintain the rosters for the provision of care. A review of duty rosters and interview with the facility manager confirmed that in addition to staff working additional shifts, agency staff are often required to fill gaps in in the rosters and cover unplanned absences. The facility had also experienced difficulties in recruiting and retaining sufficient experienced kitchen staff.</p>

		<p>The facility manager and the CSM work on morning duties, Monday to Friday inclusive and there is a RN who works three shifts between Monday and Friday as a clinical team leader. The facility is comprised of two adjoining wings, one over one hundred years old and another approximately thirty years old that includes a second level, accessed by stairs or elevator. One wing of seven beds is rest home only and the remaining are dual purpose beds. For staffing purposes, the wings are grouped into three areas based on bed numbers and acuity. There is one RN or EN on the morning and afternoon shift in each of the three areas, seven days per week and one RN on night shift for the entire facility. There is always at least one RN on duty for the entire facility. There are 11 care givers on morning duty, 10 on afternoon shift and 4 on night shift, 7 days per week. Care givers cover the entire facility, working where needed each duty.</p> <p>The facility manager and the CSM share on call after hours, seven days a week. Rosters sighted reflect adequate staffing levels to meet current resident acuity and bed occupancy.</p> <p>Observation of service delivery confirmed that residents' needs are being met. Resident and family interviews stated that they noticed staff to be busy at times, but felt resident needs are being met. Staff confirmed that they have been busy, however have sufficient time to complete their scheduled tasks and resident cares.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management system is documented and implemented and complies with legislation, protocol and guidelines.</p> <p>The service uses pharmacy pre-packaged medicine that is checked by the RN on delivery. An electronic medication system is used. Weekly checks and six-monthly stocktakes of medicines are conducted and confirmed that stock matched expected levels. Pharmacy input was verified.</p> <p>The medication refrigerator temperatures are monitored. A system is in place for returning expired or unwanted medication to the contracted pharmacy. All medications are stored appropriately. Review of the medication fridge evidenced that the service does not store or hold vaccines, and interviews with the RN and the CSM confirmed this.</p> <p>The staff administering medication complied with the medicine administration policies and procedures. Current medication competencies were evident in staff files sampled where applicable. The RNs oversee the use of all pro re nata (PRN) medicines and comments made regarding effectiveness were sighted on the electronic medication record. Observation of the lunchtime medication administration evidenced this was in line with legislation, protocols and guidelines.</p> <p>There were no residents in the facility self-administering medication during the on-site audit days. The residents who were under 65 years did not want to or were not able to self-administer their medication.</p>
<p>Standard 1.3.13:</p>	<p>PA Low</p>	<p>All meals are prepared on site. The seasonal menu has been reviewed by a dietitian, with the summer menu</p>

<p>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>implemented at the time of audit. The food control plan is current. Food management training and certificates for cooks and kitchen staff were sighted.</p> <p>Residents' dietary profiles are developed on admission and identify the residents' dietary requirements and preferences. The dietary profiles are communicated to the kitchen staff on a resident's admission to the facility, when a resident's dietary needs change and when dietary profiles are reviewed six-monthly. Diets are modified as needed and the cook interviewed confirmed awareness of the dietary needs of residents. Supplements are provided to residents with identified weight loss problems as medically required.</p> <p>Food procurement, production, preparation and disposal sighted at the time of the audit, meets the requirements of the standard. However, temperature monitoring of food being served is not carried out consistently.</p> <p>The cook is responsible for purchasing the food to meet the requirements of the menu plans. Dry food supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated. Food is also stored in fridges and a freezer; however, food is not consistently labelled and there is inconsistent temperature monitoring of the fridges and freezer.</p> <p>The cleaning schedule in the kitchen does not always evidence cleaning has occurred as expected.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>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. However, in six out of six records audited residents' cultural needs were not addressed.</p> <p>Interventions are reviewed within required timeframes and updated if there are changes in the health status of a resident. The NP documentation and records reviewed were current. Interviews with residents and families confirmed that care and treatment met residents' needs.</p> <p>There is evidence of wound care products available at the facility. The review of the wound care plans evidenced wounds are assessed in a timely manner and reviewed at appropriate intervals. Photos and measurements were taken where this was required. Where wounds required additional specialist input, this was initiated. At the time of the audit, there was one stage two pressure injury and there had been five in the preceding year.</p> <p>Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs. Monthly observations such as weight and blood pressure are completed and are up to date. Residents' family members interviewed expressed satisfaction with the care provided.</p> <p>Family communication is recorded in the residents' files. The nursing progress notes are recorded and maintained.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The residents' activities programme is implemented by an activities coordinator who works 9am to 4pm, Monday to Friday, with an activities assistant who works, 9am to 3pm, Monday to Wednesday. The weekend activities are overseen by caregivers. A diversional therapist was employed previously but has resigned and the CSM now oversees the programme. The activities coordinator has started diversional therapy training through Careerforce.</p> <p>The activities programme was displayed. A range of activities are planned which incorporate education, leisure, cultural and community events.</p> <p>The residents' activities assessments are completed within three weeks of the residents' admission to the facility. Information on residents' interests, family and previous occupations are gathered during the interview with the resident and their family.</p> <p>The activities plans are reviewed six-monthly, at the same time the care plans are reviewed.</p> <p>There was evidence the activities staff are part of the interRAI and care plan review process. The residents and their families reported satisfaction with the activities provided. Interviews with residents under the age of 65 confirmed that the activities programme meets their needs. Over the course of the audit, residents were observed engaging in 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>	<p>FA</p>	<p>Resident 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>Long-term care plans are evaluated every six-months in conjunction with the interRAI re-assessments or as the residents needs change. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Changes in the interventions are initiated when the desired goals/outcomes are not achieved. Residents and families interviewed confirmed involvement in the evaluation process and any resulting changes. Contact with family was verified and documented on the family communication record in the individual resident files reviewed.</p> <p>Short-term care plans are developed for acute problems, when needed, and record goals and the required interventions for the identified short-term problems. The short-term care plans reviewed were signed, dated and closed out when the short-term problem had resolved.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate,</p>	<p>FA</p>	<p>The facility has a current building warrant of fitness on display, located at the reception entrance. Two bedrooms in the rest home wing had been decommissioned and converted into a single dining and living room space, with no structural changes occurring. This has had no impact on the fire evacuation scheme.</p>

accessible physical environment and facilities that are fit for their purpose.		
<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>	FA	<p>The clinical team leader is the infection control nurse (ICN) and is responsible for the surveillance programme. The NP interviewed confirmed infections are reported in a timely manner.</p> <p>An infection control programme is maintained through UCG electronic data base and reporting system. Infection control surveillance occurs monthly with analysis of data and reporting at staff and quality meetings. The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infections.</p> <p>Interviews with staff reported that they are made aware of infections through handover, progress notes, short term care plans and verbal feedback from the CSM, RNs and the ICN. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The Ultimate Care Group Limited restraint minimisation and safe practice policies and procedures comply with legislative requirements.</p> <p>The restraint coordinator is the CSM who has had training in restraint minimisation and safe practice. A signed position description was sighted. The restraint register is maintained. There was one resident using a restraint (bedrails) and one resident using an enabler (bedrails) at the time of the on-site audit. Interviews with staff confirmed enabler use is voluntary.</p> <p>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)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>There is policy and process to manage complaints in line with the Code. Complaints were managed and responded to in a timely manner. However, not all aspects of the complaints process, such as advising complainants of the advocacy process, entering complaints onto the electronic database or maintaining a complaints register were consistently implemented or evidenced.</p>	<p>i) Communications to complainants did not consistently advise complaints of their right to seek advocacy through the nationwide advocacy service.</p> <p>ii) Not all complaints sighted had been entered onto the electronic data base.</p> <p>iii) A complaints register was not</p>	<p>Ensure that:</p> <p>i) Complainants are advised of their right seek advocacy, through the nationwide advocacy service.</p> <p>ii) All complaints are entered onto the electronic data base.</p> <p>iii) A complaints register is maintained.</p> <p>90 days</p>

			maintained.	
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	Residents and families are notified through various mediums of upcoming activities and events. However, the facility menu is not included in information notices. Residents meeting minutes demonstrate that residents can discuss food services and raise concerns at resident meetings.	The facility menu is not made known to residents.	<p>Ensure the current menu is posted for residents' information.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	Staff and quality meeting minutes demonstrate that quality improvement, risk management and clinical indicators are discussed at monthly meetings. These include identification of corrective actions, responsibilities and timeframes. However, infection control and health and safety minutes do not reflect quality improvement information required. Health and safety and infection control meetings are held regularly, and immediately after the staff and quality meetings	Not all aspects of quality improvements are reflected in health and safety and infection control meeting minutes.	<p>Ensure that all meeting minutes, including health and safety and infection control, demonstrate discussion, address areas requiring improvement and identify responsibilities and timeframes for close out.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>Forms are completed for all residents' incidents and or accidents. Family are notified of all resident's incidents/accidents and a detailed record of the event and family contact is documented in the resident's progress notes.</p> <p>Assessments and observations are undertaken where residents have suffered a fall, however, policy and practice for neurological observations following a resident's unwitnessed fall did not meet best practice.</p>	<p>i) Policy and procedure for neurological observations following an unwitnessed fall do not align with best practice.</p> <p>ii) Neurological observations are not completed consistently for all unwitnessed falls.</p>	<p>Ensure that:</p> <p>i) Policy and procedure for neurological observations following an unwitnessed fall align with best practice.</p> <p>ii) Neurological observations are completed for all unwitnessed falls.</p> <p>90 days</p>

<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Low</p>	<p>Aspects of food procurement, production, preparation, storage, transportation and delivery comply with current legislation; however, food temperature monitoring documentation evidenced that food temperature monitoring was not consistently carried out as per requirements.</p> <p>Not all food stored in the fridge or freezer was labelled. Documentation of completion of kitchen cleaning tasks evidenced that kitchen cleaning tasks are not undertaken consistently.</p>	<p>i) Monitoring of food temperatures is not consistent.</p> <p>ii) Food stored in the fridges and freezers is not consistently labelled.</p> <p>iii) The kitchen cleaning schedule was not completed for all cleaning tasks.</p>	<p>i) Ensure that food temperature monitoring is consistently carried out.</p> <p>ii) Ensure that all food stored in the fridge and freezers is correctly labelled.</p> <p>iii) Ensure all cleaning tasks are completed and signed off on the cleaning schedule.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Information gathered during assessments includes identifying a resident's specific cultural needs, spiritual values, and beliefs. This information informs activities that are tailored to meet identified needs and preferences. However, a review of residents' files confirmed that cultural needs identified in assessments were not consistently reflected in the residents' care plans.</p>	<p>Cultural needs are not consistently identified in the long-term care plans.</p>	<p>Ensure that assessed cultural needs are documented in the long-term care plans.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.