

# The Ultimate Care Group Limited - Ultimate Care Rose Court

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## 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:

<b>Legal entity:</b>	The Ultimate Care Group Limited
<b>Premises audited:</b>	Ultimate Care Rose Court
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 14 July 2020    End date: 15 July 2020
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	54

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
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 Rose Court is part of the Ultimate Care Group. The facility is certified to provide services for 75 residents requiring rest home or hospital level of care. There were 54 residents at the facility on the first day of the audit.

This surveillance audit was conducted against the Health and Disability Service Standards and the facility's contract with the district health board.

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

An area requiring improvement relates to the management of complaints.

## 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.

There is policy to ensure open disclosure is practiced. Staff communicate with residents following an incident and this is recorded in the resident's file. Interviews with residents and the general practitioner confirmed that the environment is conducive to communication, that issues are identified where applicable, and that staff are respectful of residents' needs.

There is a documented complaints management policy that aligns with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. Information relating to the Health and Disability Commissioners' Code of Health and Disability Consumers' Rights; the complaints process; and the Health and Disability Advocacy Service is made available to residents and their families on admission and is accessible in the facility.

## 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.

The Ultimate Care Group is the governing body responsible for the services provided at this facility. The mission and values of the organisation are documented and communicated to all concerned.

The facility has implemented the Ultimate Care Group's quality and risk management system that supports the provision of clinical care and quality improvements. Quality and risk performance are monitored through the organisation's reporting systems. An internal audit programme is implemented.

The facility has an incident and accident management system to record and report adverse, unplanned or untoward events, including appropriate statutory and regulatory reporting.

Human resource policies and procedures guide practice and there was evidence that human resource processes are being followed. There is a role specific orientation programme and ongoing training is provided. There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. Staffing levels are adequate across the services and meet contractual requirements.

## 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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Resident assessments are completed by registered nurses on admission. The initial care plan guides care and service provision for the first three weeks following admission. The interRAI assessments are completed within required timeframes and utilised to identify residents' needs. The general practitioner completes an initial medical assessment medical reviews are completed thereafter on a regular basis.

Resident care plans are developed and implemented within the required timeframes. A range of clinical information, residents' needs, goals and outcomes inform the care plan development. Evaluations are completed at least six-monthly. Residents and their relatives are involved in the care planning process. Families are notified when a residents' condition changes.

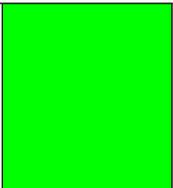
Short-term care plans are in place to manage short-term issues as they arise. Continuity of care is supported through handovers and progress reporting.

The activity programme is led by a diversional therapist.

There are medication management systems and processes in place. Review of the electronic medication management system confirmed processes and practices are in line with the legislation and contractual requirements. Medications are administered by medication competent staff.

There is a current food action plan in place. Kitchen staff have food safety qualifications. The kitchen meets food safety standards. Residents interviewed confirmed satisfaction with meals provided.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility has a current building warrant of fitness. There have been no structural alterations undertaken since the previous 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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Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the facility manager who is a registered nurse. Approved restraints are identified and information related to restraints provided to staff during orientation and ongoing training. During the time of the on-site audit, the service had two residents who were using enablers and no residents using restraint. Staff report restraint is only used as a last resort when all other options have been explored.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The facility manager leads the infection surveillance programme. The programme is appropriate to the size and nature of the service. Infection data is collected, collated, analysed and benchmarked. Staff are provided with monthly surveillance data and trends are identified.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	15	0	1	0	0	0
<b>Criteria</b>	0	38	0	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Low</p>	<p>The organisation has a complaints policy and process to ensure that that complaints are managed in line with Rights 5 and 10 of the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code). The complaint process is made available and explained to new residents on admission. The complaint forms are available in resident areas in the facility.</p> <p>The facility manager is responsible for managing complaints. A register is in place for formal complaints. Evidence relating to these formal written complaints is held in the complaints folder, with the register. Interview with the facility manager and a review of written complaints indicated that these complaints are investigated promptly, and issues are resolved in a timely manner in line with the requirements of the Code.</p> <p>Resident interviews confirmed that they are aware of the complaints process. Interviews with the facility manager described an ‘open door policy’. The facility manager is available for residents and family to discuss any issues/concerns and feedback on services. When a verbal complaint/concern is raised, the resident/family are asked if they wish to make a formal complaint and this process is explained to them. However, if they do not wish to pursue a formal complaint the issue or concern is not documented. Residents stated that they had been able to raise any issues directly with the facility manager and that these are dealt with efficiently and to their satisfaction.</p> <p>The regional manager and facility manager advised that there have been no complaints made to external agencies since the last audit.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is policy that promotes a transparent, consistent approach to full and open disclosure where there is an instance of an actual or potential adverse event and or harm during the care of a resident. The electronic incident database, residents' records and resident interviews demonstrated that where appropriate family are informed if the resident has an incident/accident; a change in health or a change in needs. Family contact is recorded on electronic incident forms and in residents' files.</p> <p>The resident admission agreement signed by the resident or enduring power of attorney (EPOA), confirms for residents what is and what is not included in service provision.</p> <p>Staff and resident interviews confirmed that family are included in resident care planning meetings. Two monthly resident meetings inform residents and families of facility activities and events. Family are welcome to attend meetings. Meetings are advertised in the facility events planner and through the facility announcement system. Meeting minutes, interviews and observation demonstrated regular attendance by residents and families. Communication with residents and their families is open and transparent, and residents have the opportunity to provide feedback and make suggestions for improvement as well as raise and discuss issues/concerns with management. Minutes of the resident meetings sighted provided evidence that a wide range of relevant subjects are discussed. Copies of the meeting minutes are available to residents on the notice boards. Copies of the activities plan, and menu are also available to residents and families.</p> <p>Resident interviews confirmed that the facility manager and staff were approachable and available to discuss queries and issues. Interviews with residents identified that concerns and queries were addressed promptly and proactively.</p> <p>There are policies to ensure that information is supplied in a way that is appropriate for the resident and/or their family. Interview with the facility manager confirmed that staff and/or external interpreter services are available if required. At the time of the audit there were no residents who required an interpreter.</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>There is a quality and risk management document that outlines the organisation's mission and values as well as detailing the business planning objectives of the organisation. The organisation's values are posted at the entrance to the facility. The values and mission statement are also communicated to all concerned through the facility's information pack provided to residents and their families on admission. Staff receive this information at orientation.</p> <p>The facility is part of the Ultimate Care Group (UCG) with the executive management team providing support to the facility. The facility manager reports to a regional manager, with support from the regional clinical lead and wider UCG executive management. Communication between the facility and the UCG executive management occurs regularly with a relieving facility manager and the facility's regional manager providing support during the</p>

		<p>audit.</p> <p>The facility provides ongoing electronic reporting of events and occupancy into the UCG national system that facilitates the review of progress against identified indicators by the executive management team. This data forms the basis of a monthly facility report. Monthly reports to the regional manager and national office demonstrated that a range of performance indicators are monitored. Copies of monthly reports are also available in the staff room for all staff to review.</p> <p>The facility manager has been in this role for one year and has four-years previous experience as a facility manager and clinical manager with UCG. The facility manager is a registered nurse (RN) with a current practicing certificate and has completed a certificate in management.</p> <p>The facility manager is supported by an acting clinical manager (ACM) who is a RN and has been in this position for one month. The ACM has just under one years' experience as an RN and has a current practicing certificate. The ACM also has two years' previous experience with the organisation as a caregiver (CG). The ACM is supported by a team of RNs.</p> <p>The facility is certified to provide rest home care, and hospital level care for up to 75 residents. Of the 75 certified beds, there were 54 beds occupied at the time of the audit, this included: 27 residents who had been assessed as requiring rest home level care, 4 of whom had occupancy rights agreements (ORA) and resided in the village; 27 assessed as requiring hospital level care and 16 residents with ORA living independently in the village wing, who had not been assessed as requiring care. Included in the total occupancy numbers was one resident under the respite care agreement who was assessed as requiring hospital level care.</p> <p>The facility has contracts with the DHB for the provision of rest home, and hospital level care; respite care; support care – end of life; and day support. At the time of the audit there were no residents receiving care under the support care – end of life and day support contracts.</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</p>	<p>FA</p>	<p>The facility utilises the UCG's documented quality and risk management framework that is available to staff to guide service delivery. Policies and procedures align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. The UCG clinical advisory group reviews all policies with input from relevant personnel. Staff have electronic access to policies and procedures via the UCG internal network. New and revised policies are presented to staff and staff interviews confirmed that they are made aware of these.</p> <p>Quality improvement, risk management, clinical indicators and corrective actions arising from quality improvement activities are discussed at monthly meetings. Meeting minutes evidenced that: quality improvement; risk management; and clinical indicators are discussed. Copies of meeting minutes are available in the staff room for all staff to review.</p> <p>The service delivery is monitored through the organisation's reporting systems utilising several clinical indicators</p>

<p>improvement principles.</p>		<p>such as pressure injuries; skin tears; infections; falls; medication errors; compliments and complaints; and weight loss.</p> <p>There was evidence that the annual internal audit programme is implemented as scheduled. Quality improvement data sighted, demonstrated that data is being collected and collated with the identification of trends and analysis of data. Where required, corrective action plans are developed, implemented, and signed off. There is communication with staff of any subsequent changes to procedures and practice through staff meetings.</p> <p>An annual residents and family satisfaction surveys are completed as part of the internal audit programme. Areas for improvement identified through surveys are implemented and discussed at staff meetings. Survey results evidenced satisfaction with the services provided. This was confirmed by resident interviews.</p> <p>The organisation has a risk management programme in place that records the management of risks in clinical, environment, and human resources. There is also a facility specific risk management plan and risk register. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Staff interviews confirmed an awareness of health and safety processes, including the reporting of hazards, accidents and incidents promptly. Health and safety events and health and safety education are discussed at staff meetings.</p> <p>Health and safety systems are implemented. Staff interview confirmed that hazard reporting occurs. There was evidence that identified hazards are addressed and risks minimised.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>The facility manager and the regional manager are aware of situations which require the facility to report and notify statutory authorities. Interviews and documentation confirmed that these are reported to the appropriate authority by the UCG support office. Since the last audit: the appointment of the facility manager and the ACM have been reported to HealthCERT (sighted).</p> <p>Interviews with staff and review of adverse event forms confirmed that staff are aware of the need to report adverse events. Staff interviews confirmed an understanding of the adverse event reporting process and their obligation to document untoward events. A review of staff records demonstrated that staff receive education at orientation on the incident/accident reporting process.</p> <p>There is an implemented incident/accident reporting process and incident/accident reporting forms are available in the staff room. Interviews with staff and review of documentation evidenced that staff document adverse, unplanned or untoward events on an incident/accident form which is reviewed and signed off by the facility manager. These are entered onto the national incident reporting database. Incident/accident reports selected for review evidenced that an appropriate assessment had been conducted. There was evidence of a corresponding note in the resident's progress notes and notification of the resident's nominated next of kin where appropriate.</p> <p>Corrective actions arising from both resident and staff incidents/accidents were implemented. Incidents/accidents</p>

		<p>data is graphed, and trends analysed. Summary reports are made available to staff on staff notice boards and discussed at monthly staff meetings. Specific learnings and results from incidents/accidents inform quality improvement processes.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>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; a signed employment agreement; position specific job description; police vetting and where required a current work visa. There was evidence that relevant staff have additional role specific job descriptions. Staff files reviewed evidenced that a performance appraisal system is implemented. Newly recruited staff complete a performance appraisal after three months and thereafter each year.</p> <p>There is a system to ensure that annual practising certificates and practitioners' certificates are current including: RNs; general practitioner (GP); physiotherapist; dietitian; pharmacists; and podiatrist.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency on a number of operational and care related tasks. Competencies such as first aid; interRAI; medication; manual handling and hand hygiene are reviewed and assessed annually. Interviews confirmed that new staff are supported until competent during their orientation into their new roles.</p> <p>A review of the staff management system and staff interviews confirmed that processes are in place to ensure that all staff complete their required training and competencies.</p> <p>The organisation has implemented the nationwide, role specific annual education and training modules. There is an electronic data base to record and track staff training/education. Staff interviews and a review of the electronic data base and education session attendance records evidenced that ongoing education is provided, and staff have undertaken a minimum of eight hours of relevant training.</p> <p>Four RNs including the ACM, have completed interRAI assessments training and competencies.</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</p>	FA	<p>The organisation's allocation of staff and duty roster policy requires a base roster be set according to the needs of the client groups, individuals and numbers. This ensures that there are sufficient staff to provide safe care in a timely manner, taking into account dependency levels and time required to provide care. Facility manager interview confirmed that rosters are adjusted to reflect changes in the acuity or numbers of residents. Rosters sighted reflected adequate staffing levels to meet resident acuity, bed occupancy and the requirements of the contract.</p> <p>A copy of each roster is made available to staff at least two weeks in advance. Staffing levels are reviewed to</p>

<p>service providers.</p>		<p>accommodate anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in residents' needs. There are sufficient RNs and CGs available to safely maintain the rosters for the provision of care to accommodate increases in workloads and acuity of residents.</p> <p>The facility is made up of two main areas, with a centrally located nurses' station that includes a mix of rest home and hospital level residents. Within the facility, at one end, is a two-winged village, which is structurally part of the aged care facility, is made up of a mix of ORA serviced apartments and care suites. There is a CG rostered to cover the ORA's between 7am and 3pm, and 4pm and 9pm each day. Outside these hours facility staff provide care for the four residents assessed as requiring rest home level care residing in the ORA's. Interview with the facility manager advised that when a resident residing within the ORA's requires a higher level of care they would be transferred to the main aged care area of the facility for care.</p> <p>In addition to the ACM who is on duty on the morning shifts typically from Monday to Friday, there is at least one RN on each morning, afternoon and night duty, seven days per week for the facility. Fifteen permanent CGs have completed the Careerforce level four, or equivalent, training. A number of these senior CGs are rostered on duty as team leaders providing additional support to RNs, with two team leaders on each morning and afternoon shift. In addition to the team leaders, there are six CGs on each morning shift, four on each afternoon shift and two on each night shift. When required additional staff hours can be sourced from staff working additional shifts, casual staff and bureaux staff as well as staff from another UCG facility in the locality. In the event that additional RN support was required after hours, the ACM or facility manager is called.</p> <p>The facility manager and/or ACM are on call after hours, seven days a week.</p> <p>Observation of service delivery confirmed that residents' needs are being met in a timely manner. Resident interviewed stated that staffing is adequate to meet the residents' needs. Interviews confirmed that staff are able to complete their scheduled tasks and resident cares over their shift. This included care of the four rest home residents residing in the ORA's.</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>There are medication management policies and processes that align with legislation and guidelines.</p> <p>Medications are stored to meet legislative requirements in two medication rooms within the facility. Medicines are stored in a manner that meets legislative requirements. Medication refrigerator temperatures are monitored and recorded weekly.</p> <p>A system to receive and return medication to the pharmacy is established. Weekly and six-monthly pharmacy stock takes are completed by the pharmacist. Medication stocks are sufficient to meet the facility's needs.</p> <p>A lunch time medication round was observed. Registered nurses, enrolled nurses and CGs administer medicines. Medication competencies for registered and enrolled nurses are completed at orientation and updated annually. Caregivers complete medication competencies when they attain level four CG qualifications and are updated</p>

		<p>annually. Syringe driver competency and education is completed by RNs annually. Staff complete competencies more frequently if they have been involved in a medication error.</p> <p>A policy is available to support residents who wish to self-medicate. There were no residents self-administering medication at the time of the audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The kitchen manager oversees food service provision. All kitchen staff have completed relevant training.</p> <p>A food control plan is in place expiring September 2020. A kitchen action plan is in place with completed actions recorded. All kitchen surfaces and floors were observed to be clean and food was stored in accordance with food safety requirements. Food, fridge and freezer temperatures are completed and documented. A regular cleaning schedule is in place. Food audits are completed as per the annual schedule. Actions related to audits are monitored, completed and signed off as required.</p> <p>Meals are prepared in the kitchen and served to residents in three dining rooms. Two dining rooms are co-located in the rest home/hospital and the third is situated in the ORA wing of the facility. Food is transported by trolley to the ORA dining room. A tray service is available where required.</p> <p>Dietary needs are assessed by the RN upon admission and as required thereafter. Information related to special diets is relayed to the kitchen in keeping with UCG policy. Residents food allergies, preferences and dietary requirements are recorded on the kitchen whiteboard. Kitchen staff discussed individual resident preferences and special diets during interview. Resident food information is updated as required.</p> <p>Staff interviewed demonstrated aware of the process to identify and record residents' changing dietary needs and diets are modified as required. High protein drinks are provided to residents at risk of weight loss. Soft and puréed food is available. Observation during a lunch time service, confirmed residents requiring assistance were supported and special diets provided. Residents interviewed reported their satisfaction with the food service.</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>	FA	<p>The residents ICPs are based on the assessed needs, goals and desired outcomes of residents. All ICPs are completed by the RN and include specific interventions for long-term and acute problems. Updates occur if the residents needs change. The GP interviewed confirmed reviews occurred within required timeframes. General practitioner records reviewed were up to date. Residents confirmed during interview that care provided meets residents assessed need. The nursing progress notes and observations are maintained. Resident files include family communication. On interview, staff confirmed they are familiar with residents' care provision to meet residents' individual needs.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is an activities programme to provide activities across the rest home, hospital and ORA's. A qualified diversional therapist leads the programme with support from an activities coordinator. Activities are provided seven days a week.</p> <p>A wide range of individual, small and large group activities are provided. These include speakers and entertainers alongside music, poetry, exercises and church services. Van outings into the community are arranged weekly.</p> <p>The resident's activities assessments are completed within three weeks of admission and reviewed six-monthly. Information is provided by the resident and their family to inform the residents profile. Activities are included in the interRAI assessments and care plans. There was evidence that more frequent reviews occur if resident's activities needs change.</p> <p>Residents on interview, articulated their satisfaction with the activities programme, the variety and suitability of activities provided. Activities were observed during audit. Families are welcome to join activities where appropriate.</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>Progress notes record the evaluation of resident care each shift. Staff identify and report resident change to the RN on duty.</p> <p>Resident care plans are evaluated six-monthly or more frequently if required following any change in the resident's condition. The RN documents the evaluation recording the degree of achievement towards the identified goals. Any change identified through the evaluation process is reflected in the residents updated ICP.</p> <p>Family involvement in the evaluation process and any resulting change in ICP was recorded and verified through family communication file review. Residents confirmed during interview their involvement and satisfaction with the evaluation process.</p> <p>Short-term care plans were developed for short term issues where required. They record goals and required interventions. Reviews occur daily and were signed by the RN, dated and closed out upon resolution of the problem. Ongoing issues were included in the ICP.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment</p>	<p>FA</p>	<p>The facility has a current building warrant of witness valid until 1 April 2021. There have been no building alterations to the facility since the last audit.</p>

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>There is an infection prevention and control programme in place suitable to the size and nature of the service. The facility manager is the acting infection prevention and control coordinator. Infection data is collated, analysed and benchmarked against other UCG facilities.</p> <p>There have been no recorded outbreaks since the last audit. Staff discussed support from the UCG senior management team related to the COVID-19 pandemic.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The facility manager is the acting restraint coordinator. A signed restraint coordinator job description reflects the coordinator role and responsibilities. A restraint minimisation policy guides practice and complies with legislative requirements. A restraint register is maintained. Restraint approval group meeting minutes confirmed restraint meetings occur six-monthly. Staff confirmed restraint is only used as a last resort when all alternative strategies are considered.</p> <p>Two residents were using enablers at the time of the audit. Both residents had completed documentation to support both voluntary requests for enabler use and regular reviews in their respective client files. Residents interviewed confirmed the voluntary nature of enabler use and methods used to minimise risks related to their use. Monitoring documentation was completed as required. No residents were using restraint at the time of audit.</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>Formal documented complaints are managed in line with the Code. The facility manager is available to meet with residents and family to discuss any issues or concerns they may have. Should they wish to escalate matters to make a formal complaint, this process is explained to them. Interview described how steps were taken to resolve issues, implement changes and inform staff. This was confirmed in staff meeting minutes. However, verbal concerns and issues are not documented through the complaints process. Residents interviews confirmed that they could discuss matters directly with the facility manager and were satisfied with the outcome of any issues raised.</p>	<p>A record of issues and concerns raised verbally by residents/family and the steps taken to resolve these are not documented.</p>	<p>Ensure that a process is implemented to ensure that all verbal issues and concerns are documented in line with the requirements of the Code.</p> <p>180 days</p>

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

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

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

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

No data to display
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End of the report.