

The Ultimate Care Group Limited - Ultimate Care Allen Bryant

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 Allen Bryant
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 September 2021 End date: 30 September 2021
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:	46

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 Allen Bryant is part of the Ultimate Care Group. The facility is certified to provide services for 46 residents requiring rest home or hospital level of care. There were 46 residents at the facility on the first day of this audit.

This surveillance audit was conducted against the subset of 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, and observations and interviews with family, residents, management, staff, and a general practitioner.

Areas identified as requiring improvement at the last certification audit relating to: care planning; assessments and facility maintenance have all been closed out.

There were no partial attainments identified at this surveillance 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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Interviews with residents, family, management and the general practitioner confirmed that the environment is conducive to effective communication.

The documented complaints management system aligns with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. Complaints are investigated and documented, with corrective actions implemented where required.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The Ultimate Care Group is the governing body responsible for the services provided at this facility.

The nurse manager is responsible for the overall management of the facility and is supported by an operations coordinator and a registered nurse team leader. Both the nurse manager and the team leader are registered nurses with current practising certificates.

The facility has implemented the Ultimate Care Group's quality and risk management system that supports the provision of clinical care and quality improvements. Meetings are held that include reporting on various clinical indicators, quality and risk issues, and discussion of identified trends.

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 is evidence that human resource processes are being followed. There is a role specific orientation programme and ongoing staff training is provided.

There is a documented rationale for determining staffing levels and skill mix 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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Service delivery is provided by staff with skills that are appropriate to the service type. Care plans are developed and evaluated within appropriate time frames. Interventions reflect current best practice. Residents and families expressed satisfaction with the care provided.

The activity programme is led by an activities coordinator, who is training to be a diversional therapist. The programme supports the physical, social and intellectual needs of the residents. The programme includes community activities.

Medication management reflects legislative requirements. Annual education is provided to staff who manage and administer medications. Residents' medications are reviewed three monthly by the general practitioner.

Meals are prepared and cooked on site. Residents' food preferences and requirements are catered for and the menu is approved by a registered dietician. Residents reported satisfaction with the food service.

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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There have been no alterations to the building since last audit at the facility. The building warrant of fitness is current.

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 a restraint and enabler policy however, no restraints are used in this service. Staff are educated on the restraint and enabler policy and de-escalation techniques. Staff demonstrated knowledge and understanding of the restraint and enabler policy and processes.

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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The surveillance programme reflects the type of service. Surveillance data is reviewed and analysed monthly, and reported to all staff across the organisation.

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 organisation has a complaints policy and process that outlines the management of complaints in line with Right 10 of the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code).</p> <p>The complaint process is made available as part of the admission agreement and explained by the NM on the residents’ admission. The complaint forms are available at the entrance to the facility. Resident and family interviews confirmed that they are aware of the complaints process and had been able to raise issues directly with the NM. These were dealt with efficiently and to their satisfaction.</p> <p>The NM is responsible for managing complaints. There had been two complaints in 2020 and two in 2021. An up-to-date complaints register is in place. Evidence relating to each lodged complaint is held in the complaints folder and register. Interview with the NM and a review of complaints indicated that complaints are investigated promptly, and issues are resolved in a timely manner in line with the requirements of the Code.</p> <p>Interviews with residents and family confirmed that they are encouraged to raise any concerns and provide feedback on services provided at the facility. There had been no external complaints lodged since the last audit, as confirmed by NM interview.</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>The organisation has a documented and implemented open disclosure policy. There are additional policies that relate to ensuring communication is appropriate for the resident and/or their family.</p> <p>Completed incident forms, residents' records and resident and family interviews demonstrated that family are informed if a resident has an incident/accident; a change in health or a change in needs. Family contact is recorded on incident forms and/or the residents' files.</p> <p>The resident admission agreement signed by the resident or enduring power of attorney (EPOA), confirms what is and what is not included in service provision.</p> <p>Resident meetings are conducted, and the meeting minutes sighted evidenced that a range of items are discussed. The residents and family are informed of the facility activities and news. Family members are welcome to attend meetings at the facility, this was confirmed at interviews with family members. The meeting minutes are available to on the facility notice board. Copies of the activities plan, and menu are also available to residents and families.</p> <p>The facility provides residents' meetings that are chaired by an advocate and these are conducted three times a year.</p> <p>Resident and family interviews confirmed that the nurse manager (NM) and staff were approachable and available to discuss queries and issues. Interviews with residents and family identified that concerns and queries were addressed promptly and proactively.</p> <p>Interview with the NM confirmed that external interpreter services are available if required. At the time of the audit there were no residents who required the services of 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>The facility business plan is current, ending in March 2022. The business plan records the Ultimate Care Group's (UCG) executive summary and values/objectives.</p> <p>The reporting lines of the organisation and the facility are documented in the UCG organisational plan. The NM reports to a regional manager, who is responsible for both regional quality and operational matters, with support from the UCG management on quality matters. Communication between the facility and the UCG executive management team members occurs regularly, confirmed by the NM interview.</p> <p>The facility provides ongoing electronic reporting of events and occupancy into the UCG's national system that facilitates review of progress against identified indicators by the executive management team. This forms the basis of a monthly facility report. Monthly reports to the regional manager and national office demonstrate monitoring of a range of performance indicators. Benchmarking against other UCG facilities occurs at a national level.</p> <p>For 2021/2022 the facility was tasked with the implementation and integration of an electronic record system.</p>

		<p>This system incorporated residents' care and facility reports.</p> <p>The facility is managed by a NM who is a registered nurse (RN) and has been in this position for over two years. The NM has more than six years' previous management experience including health of older persons, intensive care, and medical and surgical nursing. The NM is supported in the role by an operations coordinator and a team leader (TL). The TL is an RN, who provides clinical oversight on a day to day basis. The TL has been in the role for one month. Both the NM and the TL have current practicing certificates.</p> <p>The facility is certified to provide rest home care and hospital level care for up to 46 residents. There were 46 beds occupied at the time of the audit, this included: 17 residents who had been assessed as requiring rest home level care and 29 residents assessed as requiring hospital level care. Included in the total occupancy numbers were two residents under the age of 65 years, who were assessed as requiring hospital level care. There were also two residents under the palliate care contract.</p> <p>The facility has 46 single rooms of a size that are suitable for dual purpose of rest home and hospital levels of care.</p> <p>The facility has contracts with the district health board for the provision of rest home and hospital level care; respite care; chronic long-term conditions and YPD) agreement and a palliate care contract.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The facility utilises the UCG's documented quality and risk management plan. The quality and risk management plan (April 2021 to March 2022) outlines the objectives for this period. The objectives of this plan are recorded, as are the targets for improved clinical indicators. The quality indicators (such as: falls; pressure injuries; skin tears; restrain; medication) are also key performance indicators (KPIs) for the facility.</p> <p>Policies and procedures align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. The UCG's management 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. All policies are current and located on the computerised system.</p> <p>Quality improvement, risk management, clinical indicators and corrective actions arising from quality improvement activities are discussed at monthly meetings. The facility conducts meetings as per the 2021/2022 clinical meeting plan. Set meeting agendas are available on the UCG computerised system. Meeting minutes evidenced that aspects of the quality improvement, risk management and clinical indicators are discussed. Copies of meeting minutes are available for review in the staff room.</p> <p>Service delivery is monitored through the organisation's reporting systems and the newly implemented electronic record system.</p> <p>The annual audit calendar was received from the UCG head office on the first day of this audit. Audits for 2021</p>

		<p>were reviewed and evidenced the number of internal audits completed at the UCG national office and that corrective actions were implemented where required. Interview with the national office quality manager confirmed the process of the internal audit schedule as it relates to this facility.</p> <p>Quality improvement data sighted evidenced that data is being collected and collated with the identification of trends and analysis of data. Corrective action plans are developed, implemented, evaluated and signed off where required. There is communication with staff of any subsequent changes to procedures and practice through monthly meetings.</p> <p>Satisfaction surveys for residents and family are completed annually. Satisfaction survey results for 2020 evidenced satisfaction with the services provided. This was confirmed by resident and family interviews. The 2021 satisfaction survey was completed in July 2021 and the facility was awaiting results from the national office.</p> <p>The organisation has a risk management programme in place that records the management of risks in clinical, environment, and human resources. Health and safety policies and procedures are documented along with a hazard management programme. Staff interviews confirmed an awareness of health and safety processes and described an environment that encouraged the prompt reporting of hazards, accidents and incidents. Health and safety events such as: incidents and accidents; hazard identification; emergency management; health and safety projects and initiatives; and staff education and orientation are discussed at health and safety meetings. Where required appropriate training or monitoring is undertaken to address health and safety events.</p> <p>Staff interviews and hazard reporting forms sighted, confirmed that hazard reporting occurs. There was evidence that identified hazards are addressed promptly and risks minimised.</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>Management is aware of situations which require the facility to report and notify statutory authorities, including: unexpected deaths; police involvement; sentinel events; infectious disease outbreaks and changes in key management roles. Management interviews confirmed that these would be reported to the appropriate authority by the UCG national office. A pressure injury was notified to Ministry of Health on a Section 31.</p> <p>Interviews with staff and review of adverse event forms confirmed that all staff are encouraged to recognise and report adverse events.</p> <p>There is an implemented incident/accident reporting process which is managed electronically. Interviews with staff and management and review of documentation evidenced that staff document adverse, unplanned or untoward events and actions are completed as per the policy. Incident/accident reports selected for review evidenced that an appropriate assessment had been conducted and observations completed. There is evidence of a corresponding note in the resident's progress notes and notification of the resident's nominated next of kin where appropriate.</p>

		Adverse event data is communicated via facility meetings. Specific learnings and results from incidents/accidents inform quality improvement processes and are regularly shared with staff at meetings.
<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 are followed.</p> <p>There was evidence that relevant staff have additional role specific job descriptions, such as: the infection control coordinator; restrain coordinator. A performance process is in place and all files reviewed for staff employed longer than one year evidenced a current performance appraisal. New staff completed an initial appraisal after three months.</p> <p>There is a system, confirmed at data review, to ensure that annual practising certificates and practitioners' certificates are current.</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: medication; infection control; fire safety; manual handling hand hygiene are reviewed and assessed annually. Interviews confirmed that new staff are supported until competent and confident during orientation into their new roles.</p> <p>The UCG national office provide staff education and training plan for the facility. There are compulsory annual topics such as: medication competencies; infection prevention and control; restraint and manual handling. The two-yearly compulsory topics comply with the industry standards. A review of the management system confirmed that processes are in place to ensure that all staff complete their required training and competencies.</p> <p>The education session attendance records and staff files evidenced that ongoing education is provided, and staff have undertaken a minimum of eight hours of relevant training.</p> <p>Five of the six RNs (including the NM) have completed interRAI assessments training and competencies. There was an interRAI training session provided on audit days for the sixth RN.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably</p>	FA	<p>A roster is developed and reviewed to accommodate anticipated workloads and numbers of residents, to ensure safe and sufficient staffing levels within the facility to meet the needs of residents' acuity and the minimum requirements of the DHB contract.</p> <p>There are sufficient RNs and care givers (CG) available to safely maintain the rosters for the provision of care</p>

<p>qualified/skilled and/or experienced service providers.</p>		<p>to accommodate increases in workloads and acuity of residents.</p> <p>One wing of the facility mainly accommodates rest home residents and the second predominantly hospital level care residents. There is a centrally located nurses' station in each wing of the facility. The RN cover is 24 /7. There is one RN and two experienced CGs on each night duty at the facility. In the advent that additional RN support was required on the night duty, the on-call NM or the TL would be contacted. Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy and the requirements of the contract.</p> <p>The NM and TL share on call after hours, seven days a week. The operations coordinator is also available on call for non-clinical operational matters. There is after hours nursing support for shift leaders for care related questions or advice available from the national office. With the implementation of the electronic record system and access to all residents' care files, this on call support is able to be used by all UCG facilities.</p> <p>Management stated there are 59 staff, including: the NM; administration; clinical staff; activities coordinator; maintenance and household staff. Household staff include cleaners, laundry staff and kitchen staff who provide services seven day a week.</p> <p>Observation of service delivery confirmed that residents' needs were being met in a timely manner. Family and resident interviews stated that staffing is adequate for service delivery at the facility.</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 medicine management policy is current and meets requirements. The service uses an electronic medication management system and pharmacy pre-packaged medication system. All medication files sampled met legislative requirements. A medication round was observed and reflected best practice guidelines. RNs and care-staff who have completed a medication training programme and an annual competency assessment administer medications, (verified by education records). The GP interviewed confirmed that a satisfactory medication management system is in place, which includes three monthly reviews of each residents' medication.</p> <p>Medications are stored in a locked cupboard and/or in a medication trolley in the nurse's office. There are two offices that store medication, one for the rest-home, and one for the hospital. The offices are locked when there is no staff present. The offices are temperature monitored, and records sighted verified the temperature range was within an acceptable range. The medication fridge was also in the office and is also temperature monitored, with records confirming the range was within recommended guidelines.</p> <p>The service does not use standing orders, and no residents were self-administering medication.</p> <p>Controlled medications are stored and recorded as per legislative requirements, including weekly checks and six monthly stocktakes. Six monthly pharmacist audits are undertaken. Specimen signatures are kept of all staff.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All food is prepared in a kitchen on site. The service caters for the individual requirements of all the residents, including those that have for example allergies, diabetes, gluten intolerance, or require soft foods, and/or thickened fluids. The chef has appropriate knowledge and experience in meal preparation and service. There is a summer and winter menu which has been approved by a registered dietitian. The kitchen was clean and organised, with adequate supplies of fresh and canned food. All stored food had the best before date identified, and prepared food stored in the fridge was covered and dated. Cleaning records of appliances are kept, as are fridge and freezer temperature records. The food control plan is valid until June 2022. A daily diary of food provided to residents is maintained, along with temperature records.</p> <p>A dietitian visits the service monthly and liaises with the cook to make recommendations with regard to individual resident requirements when required.</p> <p>Residents interviewed stated satisfaction with the food service.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Long-term care plans sighted addressed all dimensions of the residents' health, including; physical, spiritual, cultural and emotional dimensions. The care plans sampled had been reviewed in the previous six months, and included evidence of multidisciplinary team involvement, including input from the GP, RN, CG, the physiotherapist and dietician where relevant. The care-plans sighted reflected the latest interRAI triggers. Staff interviewed described individual care-plans, knew how to access the care-plan, and the process to follow when they thought the care-plan did not meet the resident's needs.</p> <p>Short term care plans were sighted that addressed short term needs for example, a resident with an infection or other short-term problems. The care plans sighted had been evaluated and signed off when the problem had been resolved.</p> <p>Residents and family members interviewed confirmed that they were aware of, and involved in, the development of both short-term and long -term care plans.</p> <p>The previous finding that short-term care plans are not in place to guide care for all residents with infections is now closed.</p> <p>The previous finding that interventions in the long-term care plans did not document all assessed resident needs is now closed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	<p>FA</p>	<p>Long-term care-plans sampled contained interventions that reflected the residents' needs and goals, and contributed to holistic care, meeting the physical, spiritual, cultural and emotional dimensions of the residents'</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>wellbeing. All files sighted confirmed that the GP had reviewed the residents three monthly, or more frequently if required. Staff interviewed discussed the care interventions provided to residents, and were cognisant of the resident's rights, safety and dignity when delivering interventions. Interviews with residents and family members confirmed that interventions were being delivered and met expectations.</p> <p>Short-term care plans contained documented interventions for residents who had an infection, or other short-term need.</p> <p>The service had adequate continence supplies on hand to meet the needs of the residents. Sufficient and appropriate dressing supplies were sighted to meet the requirements/needs of the residents.</p> <p>Wound care plans were sighted in the clinical files and used to assess, plan, monitor and evaluate healing. The plans sighted, evidenced regular and appropriate interventions and review, and were updated in a timely manner, reflecting current best practice standards. The GP interviewed confirmed wound management was appropriate, with wounds being referred to the GP as required. The district nursing service is consulted and involved in wound care if required.</p> <p>The previous finding that assessment, treatment plans and evaluation of wounds do not comply with best practice is now closed.</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 activities programme is managed and facilitated by an activities coordinator who is currently in training to become a diversional therapist (DT). A monthly programme plan is developed that includes activities to promote physical, intellectual and communication skills. Resident attendance records are maintained.</p> <p>The activities coordinator operates the programme Monday to Friday 9.00 am to 4.00 pm. In addition, a volunteer assists with the delivery of the programme for one and a half hours twice a week. The service employs a casual DT to facilitate the programme, when the activities coordinator is unavailable.</p> <p>The activities coordinator meets each resident at admission and completes a social profile and then develops a plan based on the information obtained. This was verified in files sampled. The activities care plans had been reviewed six monthly in collaboration with the resident, an RN and family member. The activities care-plan was integrated within the resident's clinical record.</p> <p>Community outings are organised, and many residents also go on outings with family members.</p> <p>Residents who chose not to join group activities are offered/provided a one-to-one activity with the activities coordinator, which includes for example reading, playing cards, completing a jigsaw.</p> <p>Residents and family members interviewed expressed satisfaction with the programme, and stated it met their needs.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All long-term care plans sampled were evaluated six-monthly, following an interRAI assessment. Interviews with residents and their family confirmed that they had been involved in the evaluation and any subsequent modification to the care-plan.</p> <p>Short-term care plans were evaluated weekly or as appropriate to monitor response to the interventions and signed off as completed when the ailment had resolved.</p> <p>Where progress has been different from expected, the service consults with the GP, and further referral to additional service providers occurs as appropriate, for example a physiotherapist, dietician or district nurse. This was confirmed by the GP and by the resident and family member interviews.</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>	FA	<p>There is a current building warrant of fitness displayed at the facility (30 June 2022). Management stated there have been no additions or alterations to the building since the last audit.</p> <p>The partial attainment identified at last certification audit relating to maintenance records; van use and hot water temperature monitoring have been closed out.</p> <p>The maintenance records evidence that reactive and preventative maintenance is carried out. Hot water temperatures are monitored monthly and any temperatures outside of the required range are attended to. Van driving and van hoist competencies are completed by the staff who use the van.</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>	FA	<p>Surveillance of infection prevention and control includes monitoring of infection types and numbers and monitoring the use of antibiotics. The data is captured via the electronic record system used by the organisation. Two RNs who have completed appropriate training monitor the programme in the service. One of the RNs was interviewed and confirmed that audits are undertaken to ensure the surveillance programme is suitable for the service type.</p> <p>Infection control data reports were sighted, which included monthly reports that detailed the number and type of infection, with a commentary. These reports are further analysed at the organisations head office. Staff meeting minutes confirmed that the monthly data report is shared at local level with all staff members, and this was verified by staff interviewed.</p> <p>There have been no outbreaks of infection since the last audit, and surveillance data reports indicated that the infection prevention and control programme is effective, and this was confirmed by the GP. The GP also stated that a resident with a potential infection is referred to the GP in a timely fashion.</p>

		The surveillance programme is appropriate to the size and complexity of the service.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The organisation has a current restraint and enabler policy that staff in the service were able to describe. Restraints and enablers are defined. There is a designated restraint coordinator with a role description who was interviewed. The restraint coordinator is responsible for documenting and evaluating any restraint and enabler use. Education records and staff interviews confirmed that staff had received restraint, enabler and de-escalation training.</p> <p>During the audit there were no restraints in use, two enablers were in use. Documentation was sighted to confirm the enablers were voluntary and at the request of the residents.</p> <p>The GP interviewed confirmed that where restraint and enablers are considered, a discussion occurs with the GP. Restraint records, meeting minutes, NM reflection reports, staff and GP interviews confirmed that restraint was not used at the service.</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.

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.