

The Ultimate Care Group Limited - Lansdowne Court

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 Lansdowne Court
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 3 August 2021 End date: 4 August 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:	33

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ultimate Care Lansdowne Court provides rest home and hospital level care for up to 34 residents. Occupancy on the first day of audit was 33. The service is operated by Ultimate Care Group and managed by a nurse manager. They are supported by a registered nurse team leader, a regional manager and by experienced staff.

Ultimate Care Lansdowne Court residents and their family spoke positively about the care provided.

This surveillance audit was conducted against a subset of the Health and Disability Services Standards and the service's contract with the Wairarapa District Health Board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, and a nurse practitioner.

This audit identified improvements required around current policies, neurological monitoring post falls, short-term care plans and medication management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
--	--	--

The service has a culture of open disclosure. Family are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights, and a complaints register is maintained.

Residents and family interviewed verified ongoing involvement with the community.

Organisational management

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

Ultimate Care Lansdowne Court has a quality assurance and risk management programme. The quality plan is being implemented. Data is evaluated and results used for quality improvement. The service maintains a risk register and a hazard register.

The facility is managed by a nurse manager who is supported in their role by a registered nurse team leader, and the regional manager.

The quality and risk management systems include collection and analysis of quality improvement data which is monitored through the organisation's reporting systems. An internal audit programme is documented and implemented. Corrective action plans are

documented from quality activities, with evidence of resolution of issues when these are identified. Current policies and procedures support service delivery and are reviewed regularly.

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

There are human resources policies to support, recruitment practices and staff appraisals are up to date. The education planner covers compulsory education requirements as well as additional subjects.

There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

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

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

Long-term care plans are developed and implemented within the required timeframes. They are individualised and based on an integrated range of clinical information. Residents' needs, goals and outcomes are identified. All residents' files reviewed demonstrated evaluations were completed six-monthly or when the resident's condition changes. Residents and their relatives are involved in the care planning process.

Handovers between shifts guide continuity of care and teamwork is encouraged.

An electronic medication management system is in place. Medications are administered by the registered nurse and health care assistants who have completed current medication competency requirements.

The activity programme is managed by an activity coordinator. The programme provides residents with a variety of individual and group activities and maintains their links with the community. The service uses its facility van for outings in the community.

The food service meets the nutritional needs of the residents. All meals are prepared on-site. The service has a current food control plan. Kitchen staff have food safety qualifications.

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.
--	--	--

The building has a current warrant of fitness. There have been no alterations or additions to the building 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.
---	--	--

Ultimate Care Lansdowne Court has restraint minimisation and safe practice policies and procedures in place. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There were no residents using restraints or enablers on the day of audit. Staff receive training in restraint minimisation and challenging behaviour.

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 infection control programme is appropriate to the size and complexity of the service. The infection control nurse is a registered nurse. Infection data is collated, analysed, trended, and benchmarked. Monthly surveillance data is reported to staff and to the Ultimate Care Group national office. There has been one outbreak since the previous audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	2	1	0	0
Criteria	0	36	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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>	FA	<p>Complaints forms are available at the entrance to the facility. Information around the complaints process is provided on admission. A record of all complaints, both verbal and written is maintained by the nurse manager on the complaints register. This includes: the date the complaint is received; the category of complaint and a summary of the complaint; acknowledgement of the complaint in writing, the date and record of any meeting/discussion; and the date the complaint was closed/resolved. Evidence relating to each lodged complaint is held in the complaints folder with the register.</p> <p>Staff interviewed confirmed that complaints and any required follow-up is discussed at staff meetings as sighted in the minutes, and described directing anyone with issues or concerns to the most senior person on duty. Relatives advised that they are aware of the complaints procedure and how to access forms. The relatives interviewed felt comfortable discussing issues and concerns with the nurse manager and RN team leader.</p> <p>There have been no complaints lodged with the Health and Disability Commissioner or other external authorities since the previous audit.</p>
<p>Standard 1.1.9: Communication</p>	FA	<p>Comprehensive information is provided at entry to residents and relatives/whānau. Family interviewed stated that they and their relative were welcomed on entry and were given time and explanation about the services</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>and procedures. Both the nurse manager and the registered nurse (RN) team leader were available to residents and relatives and promote an open-door policy.</p> <p>Incident forms reviewed evidenced that relatives had been notified on all occasions. Relatives interviewed advised that they are promptly notified of incidents and residents' changes in health status. Residents/relatives also have opportunities to feedback on service delivery through annual surveys and resident meetings. Review of meeting minutes and interviews with residents demonstrated that resident meetings encourage open discussion around the services provided.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>During the Covid-19 lockdown relatives reported they were informed and updated of residents' wellbeing, and new policies/procedures as appropriate. Interpreter services are available when required.</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 plan, which includes the annual business plan and strategic direction, is reviewed annually. It outlines the purpose, values, direction, goals and objectives of the organisation. The documents describe annual and longer term objectives and the associated operational plan.</p> <p>The service is managed by a nurse manager who holds relevant qualifications and has been in the role for one year. The nurse manager has experience as a manager of a community hospital for over six years, and as a clinical manager in aged care for two years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through external study, regular meetings with other facility managers and relevant training courses which the organisation supports attendance. The nurse manager also has regular contact with the national office and the regional manager for the area who provide support as required.</p> <p>The service holds contracts with the district health board (DHB) for residential aged care, respite and palliative care, and long-term chronic health conditions (LTCHC). Thirty-three residents were receiving services under the contracts (sixteen rest home, inclusive of two LTCHC, seventeen hospital inclusive of two LTCHC) at the time of audit. There were no residents under DHB short-term respite contracts or younger persons with disability Ministry of Health contacts on the days of audit. There are 34 single rooms all with ensuite (dual purpose) at the facility that are used to accommodate residents assessed as requiring care for the specified DHB contracts.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>PA Low</p>	<p>The facility utilises the Ultimate Care Group's (UCG) documented quality and risk management framework that is available to staff to guide service delivery. There is a UCG monthly report provided by the national office</p>

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>following facility's entry of clinical indicators. The national office has implemented a new computerised system in December 2020, for facility's to enter their clinical indicators.</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. Policies on management of continence and managing behavioural issues were not up to date. Staff have electronic access to policies and procedures via the UCGs internal network. New and revised policies are presented to staff and staff interviews and data confirmed that they are made aware of these.</p> <p>Quality improvement activities are discussed at facility's meetings, minutes evidenced corrective action plans when these were identified.</p> <p>There was evidence that the annual internal audit programme is implemented as scheduled. Quality improvement data sighted provided evidenced that data is being collected and collated with the identification of trends and analysis of data. Corrective action plans following internal audits are developed, implemented, evaluated and signed off where required. There is communication with staff of any subsequent changes to procedures and practice through staff meetings.</p> <p>Annual satisfaction surveys for residents and family are completed and showed satisfaction with the services provided. Where there was less than 85% satisfaction found (residents meals) a corrective action had been raised and investigation and correction completed and evaluation carried out with sign off by the nurse manager.</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. 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 prompt reporting of hazards and accidents/incidents. Staff interviews confirmed that hazard reporting occurs. There was evidence that identified hazards are addressed and risks minimised. The hazard register is up to date.</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</p>	<p>FA</p>	<p>Management 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 nurse manager has been reported to HealthCERT.</p> <p>Interviews with staff and review of adverse event forms confirmed that all staff are encouraged to recognise and report adverse events. Staff interviews confirmed an understanding of the adverse event reporting process and their obligation to document untoward events. Staff receive education on the accident/incident reporting process.</p> <p>There is a documented accident/incident reporting process. Interviews with staff and review of documentation</p>

<p>an open manner.</p>		<p>evidenced that staff document adverse, unplanned or untoward events. These are entered onto the national incident reporting data base. Accident/incident reports selected for review evidenced that an appropriate assessment had been conducted. However, not all required neurological observations following unwitnessed falls had been completed (refer to 1.3.6.1). There was evidence of corresponding notes in the residents' progress notes and notification of the residents' nominated next of kin where appropriate.</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 documented. The skills and knowledge required for each position are documented in job descriptions.</p> <p>Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; a signed employment agreement; specific job description; and police vetting. There is a system to ensure that annual practising certificates (APCs) are current including for example: RNs; general practitioner (GP); pharmacists; podiatrist; and physiotherapist. Review confirmed all staff who require this, have current APCs. An annual performance process is in place, and all staff had current performance appraisals.</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: 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 management system confirmed that processes are in place to ensure that all staff complete their required training and competencies. The organisation has implemented the nationwide, role specific annual education and training modules. There is an electronic database to record and track staff training/education, which is monitored by the RN team leader. The RN team leader is responsible for managing education and training at the facility. The electronic database and education session attendance records plus paper based documents (noted the new electronic format has not been fully implemented as yet), evidenced that ongoing education is provided, and staff have undertaken a minimum of eight hours of relevant training. There is recorded evidence mandatory training has occurred for individual staff members.</p> <p>There are six RNs, including the nurse manager and RN team leader who have completed interRAI assessments training and competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe</p>	<p>FA</p>	<p>The organisation's allocation of staff and duty roster policy requires a base roster be set according to the needs of residents, taking into account dependency levels.</p> <p>Staff rosters are developed and reviewed to accommodate anticipated workloads and identified numbers of residents. Interview with the nurse manager confirmed, this ensures safe staffing levels within the facility are</p>

<p>service from suitably qualified/skilled and/or experienced service providers.</p>		<p>sufficient to meet the needs of residents' acuity and the minimum requirements of the DHB contract.</p> <p>There are sufficient RNs and care givers available to safely maintain the rosters for the provision of care to accommodate increases in workloads and acuity of residents.</p> <p>In addition to the nurse manager and RN team leader who are on duty on the morning shifts from Monday to Friday, there is at least one RN on each morning, afternoon and night duty, seven days per week. There are four care givers (7:00am – 3:00pm) on morning shifts, with a short shift care giver when the facility is at capacity (9:00am – 1:00pm). On afternoon shifts there are three care givers (3:00pm – 11:00pm) and one short shift care giver (3:30pm – 10:30pm) and two care givers on each night shift at the facility. The RN team leader covers for RN shifts when required.</p> <p>Both the nurse manager and RN team leader share on call after hours, seven days a week.</p> <p>Rosters sighted reflected adequate staffing levels to meet resident acuity and bed occupancy and the requirements of the contract.</p> <p>Family and resident interviews stated that staffing is adequate to meet the residents' needs. Staff interviews confirmed that they are able to complete their scheduled tasks and resident cares over their shift.</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>PA Low</p>	<p>A current medication management policy identifies all aspects of medicine management in line with relevant legislation and guidelines.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices are in line with legislation, protocols and guidelines. The required three-monthly reviews by the GP were recorded electronically. Resident allergies and sensitivities were documented on the electronic medication chart.</p> <p>The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. There are no standing orders used at the facility.</p> <p>Review of the medication fridge evidenced that the service does not store or hold vaccines and interview with the RN confirmed this. The medication refrigerator temperatures are monitored weekly. However, medication room temperatures are not monitored in accordance with UCG policy.</p> <p>Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration. Weekly stocktakes of medications are conducted in line with policy and legislation.</p> <p>The staff observed administering medication demonstrated knowledge and at interview demonstrated clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures. The RN oversees the use of all pro re nata (PRN)</p>

		<p>medicines, and documentation made regarding effectiveness on the electronic medication record and in the progress notes was sighted. Current medication competencies were evident on the electronic system.</p> <p>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>All meals are prepared on site and served in the dining room or in the resident rooms if requested. The seasonal menu has been reviewed by a dietitian, with the winter menu 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>Food temperatures are monitored appropriately and recorded. The kitchen was observed to be clean, and the cleaning schedules sighted.</p> <p>A nutritional assessment is undertaken for each resident on admission by the RN to identify the residents' dietary requirements and preferences. The dietary profiles are communicated to the kitchen staff and updated 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, likes and dislikes of residents. These are accommodated in daily meal planning.</p> <p>Residents were observed to be given sufficient time to eat their meal and assistance was provided when necessary. Residents and family interviewed confirmed satisfaction with the food service.</p> <p>All aspects of food procurement, production, preparation, storage, delivery, and disposal sighted at the time of the audit comply with current legislation and guidelines. The cooks are responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately in fridges and freezers. Temperatures of fridges and freezers are monitored and recorded daily. Dry food supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated.</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>	PA Moderate	<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 problems. However, short-term care plans are not developed when needed for all identified short-term problems.</p> <p>Interventions in the long-term care plan are reviewed within required timeframes and updated if there are changes in the health status of a resident. The GP and NP documentation and records reviewed were current. The NP was interviewed and verified that medical orders are followed, and care is of a high standard.</p> <p>A range of equipment and resources are available, suited to the levels of care provided and in accordance with resident's needs. There are wound care products available at the facility. The review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were</p>

		<p>taken where this was required. Where wounds required additional specialist input, this was initiated.</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. Family communication is recorded. The nursing progress notes are recorded and maintained.</p> <p>Monthly observations such as weight and blood pressure were completed and are up to date. However, neurological observations recorded following an unwitnessed fall are not completed in accordance with UCG policy and best practice.</p> <p>Residents and the family interviewed expressed satisfaction with the care provided.</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>	FA	<p>The residents' activities programme is implemented by the activities coordinator who is training to be a diversional therapist. Activities for the residents are provided five days a week, Monday to Friday, 10:00am to 4:00pm. The activities programme is displayed on the residents' noticeboards. The activities programme provides variety in the content and includes a range of activities which incorporate education, leisure, cultural and community events. Interdenominational church services are held monthly. Regular van outings into the community are arranged weekly.</p> <p>The residents' activities assessments are completed within three weeks of the residents' admission to the facility in conjunction with the RN. Information on residents' interests, family and previous occupations is gathered during the interview with the resident and their family and documented. The residents' activity needs are reviewed every six months at the same time the care plans are reviewed and are part of the formal six-monthly multidisciplinary review process.</p> <p>The residents and their family reported satisfaction with the activities provided. 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>	FA	<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 family interviewed confirmed involvement in the evaluation process and any resulting changes. However, short-term care plans are not developed and therefore not evaluated for all acute issues (refer 1.3.6).</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building warrant of fitness expires on 23 June 2022. Management and staff interviews confirmed there have been no building alteration or additions to the facility.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The UCG surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal audits are completed.</p> <p>The infection control nurse (ICN) is a RN who has completed training for the role.</p> <p>Surveillance data is collected in the clinical areas and collated monthly by the nurse manager and is accessed by the UCG national office for reporting and benchmarking. Information following monthly infection data collection is provided to staff via handover and RN meetings and staff 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>At interview staff reported they are made aware of infections via progress notes and verbal feedback from the RN and the nurse manager. However, short-term care plans are not consistently developed to guide care and evaluate treatment for all residents who have an infection (refer to 1.3.6.1).</p> <p>There has been one outbreak since the last audit. Review of documentation evidenced this was managed and reported as required.</p> <p>Covid-19 information is available to all visitors to the facility. Ministry of Health information was available on site. Infection prevention and control resources were available should a resident infection or outbreak occur.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The nurse manager is the restraint coordinator, and a signed job description was sighted.</p> <p>On the day of audit there were no residents using restraints or enablers. Restraint is used as the last resort after all other alternatives have been tried. Use of enablers is voluntary. This was evident from documentation reviewed and staff interviews. The restraint register was sighted. Restraint minimisation and safe practice education is provided to all staff at orientation/induction to the service and ongoing education is provided to</p>

		staff annually.
--	--	-----------------

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 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	PA Low	The UCGs management group reviews all policies with input from relevant personnel documents and policies are approved and updated. Electronic access to policies and procedures via the UCGs internal network is available for staff and new and revised policies are presented to staff at meetings. However, not all policies were up to date.	Policies on management of continence and managing behavioural issues had not been reviewed and were not up to date.	<p>Ensure that all documents and policies are approved and up to date.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in</p>	PA Low	Temperature of the medication fridge is monitored weekly as per UCG policy. However, the temperature of the medication room is recorded monthly.	The medication room temperature is not recorded weekly as required by the	Ensure that the medication room temperature is monitored and recorded weekly as per UCG

order to comply with legislation, protocols, and guidelines.			UCG policy.	policy. 90 days
<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>	PA Moderate	<p>The progress notes of residents with acute problems contained information about interventions for short-term issues. However, in three of the five files reviewed there was no short-term care plan developed to guide resident care when a short-term problem had been identified. Interview with staff confirmed that short-term care plans were not consistently developed for all acute problems.</p> <p>Initial neurological observations are recorded for all residents who have an unwitnessed fall. However, in documentation reviewed for six falls, neurological recordings were not carried out as required in the UCG policy or best practice.</p>	<p>i) Short-term care plans are not developed for all short-term problems.</p> <p>ii) Neurological observations are not recorded in accordance with UCG policy and best practice.</p>	<p>i) Ensure short-term care plans are developed for all short-term issues/problems.</p> <p>ii) Ensure neurological observations are recorded as per UCG policy and best practice for all unwitnessed falls.</p> <p>60 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.