

# The Ultimate Care Group Limited - Ultimate Care Madison

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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 Madison
<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: 26 November 2019    End date: 27 November 2019
<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

This aged residential care service is operated by the Ultimate Care Group Limited. Ultimate Care Madison provides rest home and hospital level care for up to 57. There were 54 residents at that facility on the first day of the audit.

This surveillance audit was conducted against the relevant Health and Disability Service Standards and the service contract with the district health board.

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

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

There are two areas identified as requiring improvement at this audit relating to current first aid certificates and food service.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights is made available to residents and family on the resident's admission.

Open communication between staff, residents and families is occurring. There is access to formal interpreting services if required.

Residents, family and the general practitioner's interviews confirmed that the environment is conducive to communication, including identification of any issues, and that staff are respectful of residents' needs.

There is a documented complaints management system and a complaints register is maintained. 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Ultimate Care Group Limited is the governing body responsible for the services provided at Ultimate Care Madison.

Business, and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. The facility has implemented the Ultimate Care Group Limited quality and risk management system that supports the provision of clinical care and quality improvement at the facility. Regular reports to the national support office are provided.

The facility is managed by a facility manager who is supported in their role by a clinical services manager. The facility management team is supported by the regional clinical quality manager and the regional operations manager.

The quality and risk management system includes collection and analysis of quality improvement data which is monitored through the organisation's reporting systems, including benchmarking. 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.

Newly recruited staff undertake orientation appropriate to their role. Practising certificates for staff and contractors who require them are validated annually. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review.

A review of rosters and service delivery staff, and resident/family interviews confirmed that there is sufficient staff available.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The facility manager and the clinical services manager are responsible for entry to service at Ultimate Care Maddison. Residents are assessed prior to entry to the service. Initial care plans are completed within required timeframes. Long term care plans are current and are based on initial assessments, interRAI outcomes and other clinical information. Care plans are reviewed six-monthly or more often as required. Interviews with residents and their families confirmed they are involved in the care planning, the review process and are kept up to date with any changes. Short-term care plans are in place to manage acute problems. Handovers and progress documentation guide continuity of care.

The activities programmes are resident focused and include activities that meet the physical, cultural and cognitive abilities and preferences of the residents. Residents are encouraged to maintain community links. Residents and families report their satisfaction with the activities programme.

Medicine management occurs according to policies and procedure. These processes are in alignment with legislative requirements and consistently implemented using an electronic system. Medications are administered by registered nurses, enrolled nurses and senior health care assistants. Medicine management competencies for staff who administer medicines are current.

The kitchen manager is responsible for food service provision. All meals are prepared on site. The food service meets nutritional requirements and individual dietary needs of the residents. There is a current food control plan. All kitchen staff have completed food safety training. Residents and families interviewed confirmed their 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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A current building warrant of fitness is displayed.

## 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 implemented. The clinical services manager oversees restraint minimisation. Staff receive training in restraint minimisation and challenging behaviour management. On the days of audit, the service had no residents using restraint and one resident requesting the use of an enabler. Restraint is only used as a last resort when all other options have been explored. Enablers are voluntary. Staff interviews confirmed understanding of the restraint and enabler 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 type of infection surveillance is appropriate to the size and complexity of the service. The clinical services manager is the infection control nurse. Monthly surveillance is conducted and reported to staff and management. This information is also reviewed by the Ultimate Care Group Limited executive team. Review of surveillance records evidenced infection rates are low and infections are followed up when required.

## 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	14	0	1	1	0	0
<b>Criteria</b>	0	37	0	1	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)
<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>	FA	<p>The facility manager is responsible for complaints management. An up-to-date complaints register is in place. Evidence relating to each lodged complaint is held in the complaints folder with the register. The complaints for 2019 reviewed, indicated that complaints are managed in line with Right 10 of the Code.</p> <p>Residents' and family interviews confirmed that residents and family can raise and discuss concerns and issues and that they were aware of the process to make a complaint. They stated any issues raised were responded to by management in a timely manner. Residents' and family had an understanding of their rights to advocacy and how to access advocacy services, particularly in relation to the complaints process.</p> <p>There had been no complaints to external agencies since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>Open disclosure policy and processes ensure open disclosure is practiced when this is required. The patient information folder provided to patients and their family on admission includes the organisation's open disclosure policy.</p> <p>Adverse events, where a resident has suffered unintended harm while receiving care are documented, investigated and communicated in an open and transparent manner. Completed incident forms reviewed demonstrated that residents and family are informed if a resident has an accident/incident; a change in health</p>

<p>communication.</p>		<p>or a change in needs. Family and residents' interviews confirmed this occurs.</p> <p>Residents' meetings inform residents of facility events and activities and provide residents with an opportunity to make suggestions and provide feedback. Minutes from the residents' meetings showed evidence that a range of subjects and issues are discussed, including but not limited to: activities; food service; laundry; maintenance; facility changes; the results of resident surveys and presentations on aspects of the Code of Health and Disability Services Consumers' Rights (the Code). The issues or concerns raised at the residents' meetings evidenced these were responded to by management. Residents and family are provided with a facility newsletter on regular basis.</p> <p>The facility enquiry information folder, provided to residents and family prior to admission to the facility, includes information on interpreter, advocacy and cultural services within the facility. The policy provides guidance for staff to ensure that residents who do not use English as their first language are offered interpreting services. The facility manager interview confirmed there were no residents at the facility requiring interpreting services at the time of the audit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The annual business plan outlines: the purpose; values; scope; direction and goals of the organisation. The values are communicated to all concerned through the facility's information pack provided to residents and their families on admission. Staff receive this information in their orientation welcome packs.</p> <p>Ultimate Care Madison is part of the Ultimate Care Group Limited (UCG) and communication between the management of the facility and the UCG executive management occurs at least monthly. The facility manager (FM) reported that regular contact with the regional manager occurs. The facility provides ongoing electronic reporting of events and occupancy that provide the UCG executive management team with progress against identified indicators. A sample of monthly reports to the regional manager and national office showed information is reported that monitors the service's performance including: financial performance; occupancy; emerging risks and staffing updates. The UCG monthly reports contain information and benchmarking against other UCG facilities in relation to key indicators, complaints and infections.</p> <p>The service is managed by a FM who has been in the role for 12 years and attends relevant training and education related to aged residential care and management. Responsibilities and accountabilities of the FM role are defined in a job description and individual employment agreement. The interview with the FM confirmed knowledge of the sector and regulatory and reporting requirements. The FM maintains their continuing professional development through attendance at meetings, conferences and continuing education opportunities. The UCG facility managers from across the region meet on a regular basis and the FM from Ultimate care Madison attends these meetings.</p> <p>The clinical services manager (CSM) commenced employment in this role in March 2018. The CSM is a registered nurse (RN) with aged residential care experience.</p>

		<p>The facility is certified to provide rest home and hospital care services for up to 57 residents, with 57 dual purpose beds, including the 54 beds occupied at the time of the audit. Occupancy included: 28 residents requiring rest home level care and 26 residents requiring hospital level care.</p> <p>The facility holds contracts with the DHB for aged-related residential care, long-term chronic health conditions; respite care and residential non-aged care.</p> <p>The facility had no residents with occupational right agreements at the time of audit.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></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>A documented and implemented UCG quality and risk management plan is accessed by staff to guide service delivery, improve quality, monitor compliance and manage risk. The plan is reviewed annually with the UCG regional operations management team.</p> <p>Policies and procedures align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. The UCG management group reviews all policies with input from relevant personnel. The facility has a master set of the policy and procedure manuals on site. A current electronic version is kept at the national support office and updated according to the review process. Staff have electronic access via the UCG intranet. New and revised policies are presented to staff and staff interviews confirmed that they are made aware of new and updated policies. The document control system reviewed evidenced referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>All aspects of quality improvement, risk management and clinical indicators are discussed at monthly facility's meetings. Staff interviews confirmed that they are kept informed of quality activities through memos and meetings. Quality data and corrective actions are discussed at staff meetings.</p> <p>Residents and family are notified of facility changes and events through the facility's residents' meetings. Residents' meeting minutes, staff and resident and family interviews confirmed that residents can have input into quality improvements and facility changes. Interviews with residents and family confirmed that residents are satisfied that the service meets their individual needs and that they are provided with choices.</p> <p>Satisfaction surveys for residents and family are completed as part of the annual internal audit programme. Surveys reviewed evidenced satisfaction with the services provided. This was confirmed by residents' and family interviews. There was evidence that corrective actions were developed and implemented for opportunities for improvement arising from resident satisfaction surveys.</p> <p>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 and their responsibilities to report hazards, accidents and incidents promptly. There is evidence of organisational activities to promote the identification and reporting of hazards. Identification forms completed when a hazard is identified and that hazards are addressed, and risks</p>

		minimised. A current hazard register is available.
<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>	FA	<p>The management team are aware of situations which are required to be reported to statutory authorities, including: unexpected deaths; police involvement; sentinel events; infectious disease outbreaks and changes in key management roles. These are reported to the appropriate authority via the UCG support office staff. Reporting to the Ministry of Health since the last audit, included appointment of the CSM.</p> <p>Staff interviewed understood the adverse event reporting process and their obligation to document all untoward events. A review of documentation confirmed that staff document adverse, unplanned or untoward events on accident/incident forms, which are signed off by the FM.</p> <p>Staff training records reviewed confirmed that staff receive education at orientation and as part of the ongoing training programme on accident/incident reporting processes.</p> <p>Accident/incident reports reviewed at audit evidenced that where appropriate the resident's family had been notified, an assessment had been conducted and observations completed. This includes all unwitnessed falls and those with a suspected head trauma having neurological observation completed. Corrective action where required arising from accidents/incidents, were implemented. Family and resident interviews confirmed that family are notified where the resident has had an accident/incident or a change in health status.</p> <p>Accident/incidents are graphed, trends analysed, and benchmarking of data occurs with other UCG facilities.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Moderate	<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; police vetting; identification verification; a position specific job description; and a signed employment agreement.</p> <p>Professional qualifications are validated and there are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff and contractors that required them.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. Care givers (CG) are buddied with an experienced staff member until they demonstrate competency on specific tasks, for example: hand hygiene; and moving and handling.</p> <p>The organisation has a documented annual education and training module/schedule that includes topics relevant to all services and levels of care provided. However, not all RNs have completed their required mandatory first aid training.</p>

		<p>The CSM and two other RNs have completed interRAI assessments training and competencies. Care staff complete annual competencies and comprehension, for example: moving and handling; hoist use; hand washing; and medication management.</p> <p>Education session attendance records evidenced that ongoing education is provided relevant to the services delivered. Interviews and training records reviewed confirmed that all staff, including RNs undertake at least eight hours of relevant education and training hours per annum. An annual appraisal schedule is in place. All staff files reviewed evidenced that staff employed for greater than one year had completed a current performance appraisal. Staff who had been employed for less than one year had completed an orientation review after three months.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The organisation's staffing and skill mix policy and formula provide guidance to ensure safe staffing levels within the facility are sufficient to meet the needs of residents' acuity and the minimum requirements of the DHB contract (refer to 1.2.7.3). Staffing levels are reviewed to accommodate anticipated workloads, identified numbers of residents.</p> <p>There are six RNs, two enrolled nurses and CGs available to maintain the rosters for the provision of care. Interview with the FM confirmed agency RNs are at times required. Rosters sighted reflected adequate staffing levels to meet current resident acuity and bed occupancy. The FM and CSM work on morning duties. There is a RN on each shift seven days per week, supported by CGs on morning, afternoon and night shifts.</p> <p>The FM and CSM share the on call after hours, seven days a week.</p> <p>Observation of service delivery confirmed that residents' needs were being met in a timely manner. Residents and family interviews stated that staffing levels meet the residents' needs. Staff confirmed that they have sufficient time to complete their scheduled tasks and resident cares.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medicine management system is documented and implemented and complies with legislation, protocols and guidelines.</p> <p>Medications are checked against the resident's medication profile on arrival from the pharmacy by a RN. Any medicines errors by the pharmacy are regarded as an incident and referred back to the pharmacy. Weekly checks and six-monthly stocktakes are completed and confirmed that stock matches expected levels. A system is in place for returning expired or unwanted medications to the pharmacy. All medications are stored in line with current legislation, protocols and guidelines. Review of the medication fridge confirmed that the service does not store or hold vaccines. The medication refrigerator temperatures are monitored and maintained within the required range.</p>

		<p>An electronic medication management system is used at the facility and meets the current legislative requirements and safe practice guidelines. Medication administration observed meets legislative requirements. Three-monthly medication reviews are completed by the GP and any discontinued medicines are managed as required.</p> <p>Staff attend annual medication education. Staff administering medicines, including RNs, enrolled nurses and senior CGs, have completed medication competencies as evidenced in staff files sampled.</p> <p>The service provides opportunity for young people with disabilities wishing to self-administer medicines, however, no residents were self-administering medications during the on-site audit days. There were no standing orders in use at time of 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>	<p>PA Low</p>	<p>The facility has a food control plan with verification conducted in July 2019. There is a rotational, seasonal menu that has been reviewed by a dietitian at organisational level. The residents' nutritional assessments are completed on admission to the facility and communicated to the kitchen staff. At interview with the FM and the cook, it was articulated that the RN completes each resident's nutritional profile on admission, with the aid of the resident and family, and the kitchen is notified of any changes. Regular nutritional assessments are completed.</p> <p>Fridge/freezer temperatures are checked and documented and there was evidence they are maintained within the required temperatures. However, the residents' fridges located in residents' rooms are not monitored for temperature control.</p> <p>Food in the fridges was observed to be covered and dated. The kitchen was clean and all food was stored off the floor. A cleaning schedule is maintained. Chemicals are stored appropriately. Decanted food is not consistently identified and dated.</p> <p>Food temperatures are recorded, however there were no records to verify the temperature probe has been calibrated as required. Residents requiring extra support to eat, and drink are assisted, this was observed during lunch.</p> <p>The residents interviewed spoke positively about the meals provided and that staff ask about their preferences.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet</p>	<p>FA</p>	<p>Wound care plans, nutrition management, skin integrity management, medical treatment plans, pain management and falls prevention plans were evident in resident files reviewed. There was evidence of referrals to specialist services such as physiotherapy; a speech language therapist; occupational therapy, the dietitian and wound care specialist nurses. The use of short-term care plans was evident for acute problems.</p> <p>Progress notes and observation charts are maintained. Family communication is recorded in the residents'</p>

<p>their assessed needs and desired outcomes.</p>		<p>files, diaries and in the accident/incident records. Interview with the GP confirmed they provide 24-hour, 7 day a week support. Medical records identified reviews are completed at least monthly or more frequently if needed. The GP is satisfied with the care and reported that RNs contact, and implementation of care, is timely, when concerns about a resident's condition are made.</p> <p>Staff interviews confirmed supplies of products and equipment are available to meet the residents' needs. Staff interviews confirmed they are familiar with the needs of the residents they are allocated to.</p> <p>In interviews, residents and family members reported that residents' individual needs are appropriately met, and they are actively involved in planning of care.</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 diversional therapist (DT), CGs and volunteers provide an activity programme which aims to address the residents' needs, age and cultural preferences. There is one programme which includes activities for both rest home and hospital levels of care. The activity programme is provided seven days a week. Activities provided over the weekend are supported by CGs. The programmes are made available to all residents and their families weekly. The DT interviewed explained the variety of the programme, community involvement and the inclusion of exercise activities and activities of resident choice. Activities provided reflect ordinary patterns of life and includes, but not limited to, games, entertainers, crafts, exercise classes, singing and weekly van outings.</p> <p>The service had a younger person under the age residential care contract, for whom they provide additional activities, including additional social activities and community links to meet their specific needs. There is a weekly van outing for residents to accommodate shopping, banking and other needs. On the day of audit, residents including younger persons, were observed being actively involved with a variety of activities. Some residents attend activities of interest in the community. Residents who prefer to stay in their room can have one-on-one visits including, for example, reading, hand massage and music.</p> <p>Residents have an assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career and family. Attendance records are maintained. The activity monthly progress reports are entered in the residents' clinical files and record outcomes against goals. Resident files reviewed identified that the individual activity plan is reviewed six-monthly. Residents and families interviewed commented positively on the activity programmes provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>There was documented evidence that RN evaluations are current and completed for all care plans sampled. Resident files sampled evidenced at least six-monthly care plan reviews are completed. Reviews include the degree of achievement towards meeting desired goals and outcomes. Resident care is evaluated on each shift and reported in the residents' progress notes. Changes to the residents' condition is reported to the RN or the</p>

comprehensive and timely manner.		<p>CSM.</p> <p>A short-term care plan is initiated for acute concerns, such as infections, falls and wound care. Interviews verified residents and family are included and informed of all changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building warrant of fitness is current and displayed at the facility. There has been no structural building alterations since the last audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The UCG infection control surveillance policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal audits are completed. The CSM is the infection control nurse. Infection data is collated monthly by the CSM and is submitted to the UCG national office where benchmarking is completed. This data is analysed for trends and reported at the monthly infection control meetings.</p> <p>Interview with the CSM confirmed there had been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Ultimate Care Madison restraint minimisation and safe practice guidelines and policies comply with legislative requirements. The restraint coordinator is the CSM, who has a signed position description, which was sighted. The clinical and quality team are responsible for approving any form or type of restraint practice used at UCG facilities nationally. Restraint is only used as last resort once all alternative strategies are considered. Enablers are voluntary, and the least restrictive option is in use to maintain resident independence and safety.</p> <p>The restraint register is maintained and current. There were no residents using restraint and one resident using a lap belt as an enabler during the on-site audit days.</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 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>Staff practicing certificates were noted to be current for staff who required these and processes were in place to ensure these were effectively managed. There are six RNs at the facility (excluding the CSM).</p> <p>Three of the six RNs do not have current first aid certificates. One of two enrolled nurses have current first aid certificates. Staff rosters evidenced there are night duties that do not have a staff member with a current first aid.</p> <p>The FM arranged/booked first aid training for staff and evidence of this was sighted at the audit.</p>	<p>Not all RNs have current first aid training.</p>	<p>Ensure all staff required to have current first aid have completed this training.</p> <p>30 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage,</p>	<p>PA</p> <p>Low</p>	<p>The kitchen fridge, freezer and chiller temperatures are checked and documented. Residents have fridges in their rooms and there was no recorded evidence the</p>	<p>i) Residents' food fridges are not monitored</p>	<p>Provide evidence of:</p> <p>i) Residents food</p>

<p>transportation, delivery, and disposal comply with current legislation, and guidelines.</p>		<p>residents' fridges were monitored for temperature control.</p> <p>There was evidence of decanted foods being dated in the dry storage areas. Breakfast food is being decanted and located in the kitchen area. This decanted food was not dated.</p> <p>Food temperatures are recorded. A new temperature probe had been purchased, however, there were no records to verify the temperature probe has been calibrated as required.</p>	<p>for temperature.</p> <p>ii) Decanted food is not always dated.</p> <p>iii) Calibration of the food temperature thermometer is not documented.</p>	<p>fridges are monitored for temperatures.</p> <p>ii) Decanted food is dated.</p> <p>iii) Calibration of the food temperature thermometer is documented.</p> <p>180 days</p>
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## 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.