

Mateus Enterprises Limited

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 Health and Disability Auditing New Zealand 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: Mateus Enterprises Limited

Premises audited: Seaview Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 2 July 2015 End date: 2 July 2015

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: 23

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

Seaview home provides rest home level care for up to 28 residents. On the day of the audit there were 23 residents. The service is owned by four owners. One owner is a registered nurse and is the clinical manager. She lives close by to the facility to provide after-hours support. Another owner is the facility manager and the other two owners have input into maintenance and support. The service continues to have a low staff turnover. Staff interviewed were knowledgeable and skilled. The residents and family members interviewed spoke very highly of the support provided. The quality and risk management programme continues to be implemented.

This unannounced surveillance audit was conducted against a subset of the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The service has addressed seven of nine previous certification audit findings relating to the conducting assessments, medication management, medication competencies, food temperature monitoring, testing of electrical equipment, restraint monitoring, and annual review of the infection control programme. Improvements continue to be required around completing the internal audit programme and aspects of care planning.

This surveillance audit identified further improvements required in relation to timeframes for completing aspects of care planning.

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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Communication with residents and families is appropriately managed. Complaints are actioned and include documented response to complainants. A complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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There is an implemented quality and risk programme that involves the resident on admission to the service. A business plan, quality assurance and risk management plan is being implemented for 2015. Policies and procedures have been reviewed to reflect the activities of the service and align with current guidelines and legislation. Corrective actions are identified, implemented and followed through following audits and feedback from residents and staff. Staff and resident meetings have been held. Feedback is sought from residents and families. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are appropriately managed with reporting to staff evident in meeting minutes reviewed. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Human resource policies are in place to determine staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The clinical manager is responsible for care plan development with input from residents and family. The service is utilising the InterRAI assessment tool. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are administered in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Kitchen staff are trained in food safety.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The service displays a current building warrant of fitness which expires on 1 July 2016.

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.

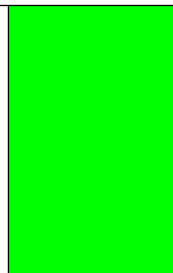


Standards applicable to this service fully attained.

Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are the least restrictive. There are no residents requiring restraint or enablers.

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 type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. No outbreaks have been reported in the past 10 years.

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	2	1	0	0
Criteria	0	40	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>The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff interviewer were aware of the complaints process and to whom they should direct complaints. A complaints register is maintained and evidenced that complaints have been appropriately managed and responded to. Residents and family members advised that they were aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Six residents and three family members interviewed stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Communication with family members is recorded on the sample of eight incident and accident report forms reviewed and in the associated resident files. Residents meetings have been held three monthly. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). If residents or family/whānau have difficulty with written or</p>

		spoken English then the interpreter services are made available.
<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>	FA	<p>Seaview rest home is certified to provide rest home level care for up to 28 residents with 23 residents on the day of audit. There were no respite residents and no one under the age of 65. The registered nurse clinical manager is experienced in aged care and has been in the role for the past 20 years. She maintains an annual practicing certificate. The clinical manager (also an owner) is supported by three other owners – one of whom is the facility manager. A registered nurse is also available on a casual basis to relieve the clinical manager and to provide on-call cover.</p> <p>There is a documented business plan for 2015-2017, which includes the quality and risk management programme and mission statement and philosophy. The service has an annual audit schedule to monitor the goals and service delivered (link #1.2.3.6). Quality data is collected analysed and communicated to staff via the staff meetings. The manager and clinical manager have each maintained at least eight hours annually of professional development.</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>	PA Low	<p>Seaview rest home has an established and implemented quality and risk system that include analysis of incidents, infections and complaints, internal audits and feedback from the residents.</p> <p>There is a business plan in place for 2015-2017 and a quality and risk management plan which is being implemented. Quality improvement initiatives have also been implemented and are developed as a result of feedback from residents and staff, audits, and incidents and accidents. Progress with the quality and risk management programme is monitored through the staff meetings. Monthly and annual reviews are completed for all areas of service. Meeting minutes are maintained and staff are expected to read the minutes and sign off when read. Minutes for staff meetings include actions to achieve compliance where relevant. Discussions with the clinical manager and four caregivers confirm their involvement in the quality programme. Resident/relative meetings have been held three monthly.</p> <p>There is an internal audit schedule in place for 2015. All audits with the exception of clinical file audits have been conducted for 2015. Areas of non-compliance identified through quality activities are documented as corrective actions, implemented and reviewed for effectiveness. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard</p>

		<p>management. Emergency operations and contingency plans are in place. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures align with the resident care plans.</p> <p>Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. The service collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow up where required. Families are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</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>	FA	<p>Incident and accident data is collected and analysed and reported to staff. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of eight resident related incident reports for April and May 2015 were reviewed. Incident rates are low with minimal falls, skin tears and bruising reported. All reports and corresponding resident files reviewed evidence that appropriate and timely clinical care by the clinical manager or the on-call registered nurse had been provided following an incident. Reports were completed and family notified as appropriate. Incidents and accident data is communicated to staff, as evidenced in meeting minutes reviewed and staff interviews. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise reoccurrence.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates for the registered nurses are kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed for three caregivers, the activities coordinator and the clinical manager and included all appropriate documentation. Annual appraisals have been completed. The service has an orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. There is a completed in-service calendar for 2014 which exceeds eight hours annually and a plan for 2015 underway. Caregivers have completed either the national certificate in care of the elderly or have completed or</p>

		commenced the career force aged care education programme. The manager and clinical manager have attended external training including conferences, seminars and sessions provided by the local DHB.
<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>	FA	Seaview rest home has a four weekly roster in place which ensures that there is at least one staff member on duty at all times and a registered nurse on-call. The clinical manager works 40 hours per week and is on-call after hours and weekends. Caregivers advise that sufficient staff are rostered on for each shift. All care staff are trained in first aid. Residents and families interviewed advised that there is sufficient staff on duty to provide the care and support required.
<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>	FA	<p>The service uses individualised medication packs, which are checked in on delivery. A caregiver was observed administering medications correctly. Staff who are responsible for administering medications are assessed as competent to do so. Medications and associated documentation were stored safely and securely. Medications are reviewed three monthly with medical reviews by the attending GP. Resident photos are current and documented allergies are recorded on all 10 medication charts reviewed. An annual medication administration competency including observations, have been completed for staff administering medications including the clinical manager and the on-call registered nurse. The service has addressed this previous finding. Medication training had been provided. Two staff sign for medication where applicable to do so. The previous audit findings relating to conducting weekly checks of controlled drugs and three monthly reviews by the GP have now been addressed.</p> <p>There is a self-medicating resident's policy and procedures in place. There were no residents self-administering medications on the day of audit. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. All medication charts reviewed record an indication for use for as required medications and are signed individually by the GP. Medications are managed, stored and administered in line with accepted guidelines and legislation.</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	All meals at Seaview rest home are prepared and cooked on site. There is a four week winter and summer menu, which has been reviewed by a dietitian in April 2015. Meals are prepared in an equipped kitchen adjacent to the dining room and served directly to the residents. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. The previous audit finding around monitoring of hot and cold foods has now been addressed. Staff were observed

		<p>assisting residents with their lunch time meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known and any changes are communicated to the kitchen. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required. Resident meetings are held and there is an opportunity for resident feedback on food services. Residents and family members interviewed indicated satisfaction with the food service.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission, which formed the basis of resident goals and objectives. InterRAI assessments were completed within three weeks in three of five files reviewed (link #1.3.3.3). The InterRAI assessment has been repeated at six month intervals (one exception link #1.3.3.3). The InterRAI assessed needs are reflected in care plans reviewed. The service has addressed this previous finding.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Care plans reviewed for five residents evidenced that interventions recorded are based on the InterRAI assessment and the clinical assessment protocols (CAPs) triggered through the assessment process. All five care plans were resident centred and individualised. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Short term care plans were in use for changes in health status for residents with infections and wounds. Those sighted were evaluated on a regular basis and signed off as resolved. There was evidence of service integration with documented input from a range of specialist care professionals including wound care specialist. The InterRAI care plan was comprehensive and captured all identified care issues for two of five resident files reviewed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Care plans reviewed for five residents are based on the InterRAI assessments conducted. Interviews with the clinical manager, caregivers and residents evidence resident and family input.</p> <p>Dressing supplies are available and adequately stocked for use. Wound assessment, wound treatment, frequency of dressings and evaluations for two residents with wounds, were documented and linked with a short term care plan. Pressure area cares and interventions are documented in the care plan for one resident. There were no residents with pressure injuries. The RN interviewed advised that they have access to external to wound specialist as required.</p>

		<p>Specialist continence advice was available as needed and this could be described.</p> <p>Monitoring forms in place include (but not limited to); monthly weight, blood pressure and pulse, food and fluid charts and blood sugar levels.</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 activities coordinator provides an activities programme over five days each week. Weekend activities are spontaneous and supervised by weekend care givers. Activities planned for the day were displayed on a notice board. An activity plan is developed for each individual resident based on assessed needs. The activity plans were reviewed at the same time as the care plans in resident files sampled. Residents were encouraged to join in activities that were appropriate and meaningful and to participate in community activities. The service has a van that is used for weekly outings. Residents were observed participating in activities on the day of the audit. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed are updated as changes were noted in care requirements. Care plan evaluations are comprehensive and include a reassessment of the InterRAI assessment tool. A new care plan is then developed as evidenced in two resident files reviewed (link #1.3.3.3). Two of five residents do not yet require care plan evaluations. Short term care plans are utilised for residents with wounds and infections and files reviewed evidenced sufficient detail in the short term care plans to guide care staff (link #1.3.5.2). Any changes to the long term care plan are dated and signed. One of five care plans was not evaluated within the required time frame (#1.3.3.3). Two of five care plans were evaluated six monthly or more frequently when clinically indicated. Initial care plans sighted for five of five files had been evaluated by the RN within three weeks of admission.</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>Seaview rest home displays a current building warrant of fitness which expires on 1 July 2016. Electrical testing and tagging has been conducted and medical equipment has been serviced and calibrated. The service has purchased a new set of chair scales in September 2014. The previous finding has been addressed and monitored.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers,</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection</p>

<p>and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>control (IC) nurse and clearly defined guidelines. The infection control programme is linked into the quality management programme. The infection control committee includes all staff and is discussed at the monthly staff meetings. The IC programme for 2013 and 2014 has been reviewed. The service has addressed this previous finding. The facility has developed links with the GP's, local laboratory, the infection control and public health departments at the local DHB.</p>
<p>Standard 3.5: Surveillance 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>Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection prevention and control policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. The clinical manager at Seaview is the infection control nurse. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly facility infection summary and staff are informed. This data is monitored and evaluated monthly and annually. Infection control education has been provided. There have been no outbreaks in the past 10 years.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Documented systems are in place to ensure the use of restraint is actively minimized. The facility was not utilising restraint or enabler use on audit days. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Enablers are voluntary. Restraint use is reviewed via quality assurance meetings and education and audits are completed.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are followed. There is an assessment form/process that is available for restraint use. No residents are currently assessed for restraint. Monitoring forms that included regular two hourly monitoring (or more frequent) were utilised for a previous resident who had been on restraint (bedrails) and no longer resides at the facility. Consent forms detailing the reason and type of restraint were completed. The service has a restraint and enabler register which is reviewed six monthly. The service has addressed the previous certification finding.</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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>The previous certification audit identified that not all internal audits had been completed as per the annual audit schedule. The internal audits for 2015 were reviewed and evidenced that internal audits relating to the environment, staff files, medication management, hand hygiene, complaints, kitchen food safety, and activities have been conducted. Corrective actions have been completed for areas of non-compliance. A resident survey was conducted in August 2014 around meals, medical and clinical care, safety, cleaning, laundry and activities. The overall response was very positive with 100% of respondents advising that they are more than satisfied with the care and</p>	<p>The clinical file audit was last conducted in June 2014. This internal audit was due again in December 2014 and June 2015. These audits have not been completed.</p>	<p>Ensure that the internal audit of residents files and care planning is completed as per the audit schedule.</p> <p>90 days</p>

		services provided at Seaview.		
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>The service is utilising the InterRAI assessment tool as evidenced in five of five resident files reviewed. Three InterRAI assessments have been completed within the required time frames. Care plans are evaluated and the InterRAI assessment repeated six monthly in two files reviewed. Two long term care plans are not yet due for evaluation. One care plan has not been reviewed within the six month time frame.</p>	<p>a) one resident had been assessed with InterRAI and a long term care plan developed in 2013 but has not had this reviewed since; b) advised that one resident had InterRAI assessment completed on admission and long term care plans developed 21 days after admission, however, these could not be located. The next InterRAI assessment and the long term care plan were dated six months after admission; c) one resident's InterRAI assessment was completed four weeks after admission and the long term care plan completed two months after admission.</p>	<p>Ensure that all aspects of care planning, assessments and evaluations are conducted within the required timeframes.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	<p>Short term care plans were in use for two residents – one with a chronic wound and one with an infection. The long term care plan is based on the InterRAI assessment conducted for all residents. The long term care plan addresses only those care deficit issues (CAPs) identified through the InterRAI assessment process.</p>	<p>a) One resident did not have a short term care plan developed for acute changes in diabetes status, changes to insulin regime and increased blood sugar monitoring. The monitoring was evidenced as being conducted as per the GP instructions and insulin had been given as per the medication chart; b) one resident did not have a short term care plan developed for exacerbation of congestive heart failure. The long term care plan did not capture interventions being provided for nutrition, mobility or skin care; c) one resident did not have a short term care plan developed for temporary fluid restriction and congestive heart failure monitoring. The long term care plan did not include interventions being provided for mobility, continence, and skin care;</p>	<p>Ensure that short term care plans are utilised for short term health issues and that long term care plans describe the required interventions to meet the residents assessed needs.</p> <p>60 days</p>

			d) one resident did not have long term care plan interventions documented around pain management; e) one resident whose condition has deteriorated to the point of requiring end of life care does not have this documented in a short term care plan. The long term care plan is no longer relevant to the current health status.	
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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.