

Maygrove Care 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 The DAA Group 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:	Maygrove Care Limited
Premises audited:	Maygrove Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 4 August 2015 End date: 4 August 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:	46

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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

The Maygrove Village hospital is part of the Maygrove Retirement Village Complex. The service provides rest home and hospital level of care for up to 50 residents.

An unannounced surveillance audit was conducted against the Health and Disability Services Standards and the services' funding contract with the Waitemata District Health Board. The onsite audit included the review of documentation and residents' files, observations and interviews. Interviews were conducted with management, staff, residents, family/whanau and a general practitioner to verify the documented evidence. This audit report is an evaluation of the combined evidence on how the service meets each of the relevant standards.

This audit included the follow up of the one shortfall identified in the previous certification audit, related to the evaluation of care. This area still requires further improvements to fully embed into practice. From this audit there are new areas identified as requiring improvement in the assessment and care planning time frames and documentation, medication management and kitchen services.

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 is open and honest, with this being reported as one of the strengths of the service. The resident, and where appropriate, their family, are informed of any adverse events. When required the service has access to interpreting services.

There is an easily accessible complaints process. There are no outstanding complaints at the time of audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The service is managed by a suitably qualified and experienced facility manager. The organisation's mission statement and vision have been identified in the business plan. Planning covers business strategies for all aspects of service delivery in a coordinated manner to meet residents' needs.

The quality and risk system and its processes support safe service delivery. Corrective action planning is implemented to manage any areas of concern or deficits identified, with documentation showing the evaluation and follow up of the corrective actions. The quality management system included an internal audit process, complaints management, resident and relative satisfaction surveys and incident/accident and infection control data collection. Quality and risk management activities and results are shared among staff.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and meet legislative requirements. The staff receive ongoing education that reflects current accepted good practice.

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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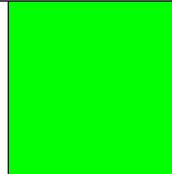
Care and interventions are provided to meet the residents' needs. Timeframes are not met related to assessment processes and do not meet DHB contractual requirements. The documented care plans identify each resident's physical, psycho-social, cultural and spiritual needs following an interRAI assessment. The information on the resident's care plan does not always match assessment findings. There is a plan in place to show when each resident's six monthly evaluation of care is due. This process is not up to date. The evaluations which are undertaken do not show how each resident's progress towards attaining set goals is progressing. Policy requires short term care plan use for issues that can be resolved, such as infections. No short term care plans were sighted. Staff demonstrated knowledge in providing interventions and services for the residents. This is supported by resident and family/whānau interviewed who reported a high level of satisfaction with the care provided.

Planned activities are based on the interests and strengths of the residents.

There is a comprehensive policy and procedures in place for medication management. Staffs receive regular education to ensure ongoing competence with medications. Safe storage and administration of medicines was understood by staff spoken to. Two areas do not comply with legislative requirements, these relate to transcribing of prescription medications and standing orders.

The menu is currently under dietetic review to ensure it is appropriate and meets nutritional requirements of the residents. The kitchen is resourced appropriately and staff are aware of resident's individual needs. Issues regarding safe and appropriate storage of food items were identified and measures need to be put in place for decanting foods from original packaging and dating foods in the pantry and fridge/freezer.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current building warrant of fitness. There has not been any change to the layout of the building that has affected the building warrant of fitness or approved evacuation scheme.

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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Bed rails and lap belts are the approved restraints in use. When enablers are used they are voluntary and the least restrictive option to maintain the resident's independence, safety and mobility. Restraint and enabler use is clearly documented in the resident's care plan.

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.

There is monthly surveillance of infections. This infection data is collated and analysed. When trends or an increase of infections are noted, actions are implemented to reduce the reoccurrence. The staff demonstrated sound infection prevention and control practices and knowledge.

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 Standards applicable to this service 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	11	0	4	1	0	0
Criteria	0	32	0	5	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>There are complaints forms available and easily accessible and displayed at the reception area. The complaints sampled comply with time frames of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Where possible the organisation tries to exceed this time frame and address any complaints within two working days.</p> <p>The residents and families reported that it is easy to make a complaint if they wish to. Staff demonstrated awareness of how to manage a complaint. Complaints have been received through the formal complaints form, verbal or email feedback.</p> <p>The complaints sampled included the nature of the complaint, investigation, actions taken and follow up to the complainant. The complaints register records the dates, complaints and how they were addressed.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to</p>	FA	<p>Residents and family report they receive open and honest communication from staff and management. They report that being kept informed and the way that the staff communicate with them is a 'real strength' of the service.</p> <p>The service has processes for accessing an interpreter. There are some residents</p>

effective communication.		who have English as their second language, though staff report that they are able to communicate effectively with all residents.
<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>The service provides rest home and hospital level of care for up to 50 residents. At the time of audit there were 46 residents, which included two rest home residents and 44 hospital level of care residents. Services are planned to meet the needs of the residents at mostly hospital level of care, with the rest home level of care provided for residents who transition from the retirement village.</p> <p>The mission and philosophy of the organisation is displayed throughout the service. The strategic directions are reflected in the annual quality and business plan (sighted for January 2015 to December 2015). This plan sets goals for the key components of service delivery. The goals are reviewed at least four times each year at the quality meetings.</p> <p>The facility manager is a registered nurse (RN) with a current practising certificate. The facility manager's position description outlines their responsibilities and accountabilities. The facility manager has been in the role since March 2015, prior to that they were acting in the facility manager's role on a relief basis. The manager has responsibility for the overall running of the care facility, which is part of the larger retirement village, and reports to the company director. The facility manager's last performance appraisal records that they are meeting the objectives of their role. The facility manager is a member of an aged care organisation and attends over 8 hours education each year related to the management of a care facility. The manager also maintains their clinical knowledge and attends education related to aged care and the aging process. The facility manager has also completed interRAI assessment training. They are supported by a nurse advisor, a clinical manager and two assistant clinical managers.</p> <p>Staff reported that the manager is approachable, listens and addresses any concerns and runs the service in a flexible and organised way. Staff reported that good communication from management is one of the strengths of the organisation.</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</p>	FA	<p>The quality and risk management systems cover the key components of the service delivery. There are separate infection control, health and safety and restraint meetings. The quality meeting further reviews all the outcomes and issues reviewed at each of the other meetings. The quality and risk management systems</p>

<p>reflects continuous quality improvement principles.</p>		<p>are monitored through an internal auditing schedule, quality action reports, feedback from complaints and review of incidents and accidents. Internal audits include the objective, method, results and recommended actions and follow up to ensure the actions are effective. Information is shared with all staff with meeting minutes and results displayed on the staff notice board. Quality improvement data is collected, analysed, and evaluated by the appropriate committee (such as health and safety, restraint) then also reviewed at the quality meeting. The quality meetings measure achievement against the quality and risk management plan. The internal audits sampled evidenced corrective planning to address any shortfalls. Feedback is provided to the appropriate levels of staff, for example food services to the cook, clinical audit outcomes to the caregiving staff.</p> <p>Policies and procedures are developed at the organisational level, with these reviewed by the nurse advisor and facility manager. The higher risk policies, such as health and safety, infection control and restraint are reviewed at least annually. Other policies are reviewed at least three yearly or when there are changes to legislation or best practice. Staff only have access to the most recent policy, with all documents version controlled.</p> <p>Staff, residents and family/whānau confirmed any concerns they have were addressed by management and gave verbal examples of quality improvements made.</p> <p>Actual and potential risks were identified and documented in the hazard register. There were interventions implemented to either eliminate, isolate or minimise the hazards. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Management understands their obligations in relation to essential notification reporting and knew which regulatory bodies must be notified. There have been no incidents or accidents that have required essential notification. The facility manager reports that if there are any fractures or pressure areas, they would notify the DHB about these. Staff reported they report and record all incidents and accidents.</p> <p>Incident and accident reporting processes are well documented and any corrective actions to be taken were shown on the forms used by the service. Families are notified of any adverse, unplanned or untoward events at times they have nominated. Family/whānau confirmed they are kept well informed of any concerns</p>

		<p>the staff may have or of any adverse events related to their relatives. Management confirmed that information gathered from incidents and accidents is used as an opportunity to improve services where indicated.</p>
<p>Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Staff who require professional qualifications and annual practising certificates (APCs) have these validated as part of the employment process. A register is maintained of the staff and contractors who require an APC, with current APCs sighted for all who require them.</p> <p>Policies and procedures are implemented for human resources management that reflects good employment practice and meets the requirements of legislation. Newly appointed staff are police vetted upon employment, references are checked and job descriptions clearly describe staff responsibilities and best practice standards. Staff have completed an orientation programme with specific competencies for their roles.</p> <p>Staff undertake training and education related to their appointed roles. Records of attendance and competency training is maintained. Education provided is refined to current accepted good practice, with staff providing feedback and evaluation of the in-service education provided. The education programme covers the contractual requirements, staff competencies and specific issues related to the aging process. The service has completed the required RN training on the interRAI assessment tool, with four RNs currently trained and further RNs planned for training.</p>
<p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Policy identifies staffing levels and skill mix are maintained to meet residents' needs and to comply with the funder's contractual requirements and safe staffing guidelines. Rosters identified that at all times there are adequate numbers of suitably qualified nursing and care staff on duty. Staff are allocated per each wing of the facility for morning and afternoon shifts, with the staffing rostered for the whole facility at night. A review of rosters showed that staff were replaced when on annual leave or sick leave. There are appropriate numbers of physiotherapy, physiotherapy assistants, administration, activities and cleaning staff to meet the needs of the service and residents.</p> <p>The facility manager reported that additional staff would be rostered to meet residents' needs and this was confirmed by staff interviewed. This occurred during a recent infection outbreak. Staff interviewed confirmed there are adequate staff on</p>

		<p>each shift and that they have time to complete all tasks to meet residents' needs. The retirement village is staffed separately from the aged care facility. Residents stated their needs are met in a timely manner.</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>	PA Low	<p>The medication practices observed during the lunchtime medication round were appropriate and consistent with the medication policy. Random samples of medication checked were all within expiration date and eye drops were clearly labelled with the date of opening. The content of the standing orders and current transcribing practice does not meet legislative requirements.</p> <p>There is a policy and procedures which document providers' responsibilities with medication management including competence, documentation (including allergies) and resident consent.</p> <p>There is one resident who self-administers their medications. As part of the medication policy there is a process for residents who wish to self-administration medication, which includes informed consent, initial assessment of competence and ongoing review.</p> <p>All staff who administer medications are trained and assessed as competent as part of their orientation and have six month in-house refreshers.</p> <p>Sighted "as required" prescription medications had clear indications for use and complied with current 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>	PA Low	<p>The kitchen is managed as part of the village complex and not located within the hospital area. The menu is currently under dietetic review to ensure it is appropriate for the nutritional needs of the residents. The last dietetic review was May 2012.</p> <p>There is a board noting residents' dietary preferences, dietary modifications and special diets. All residents' files have a dietary profile which are available to kitchen staff.</p> <p>Residents eat meals in the dining room or in their own rooms if this is required to maintain dignity or if specifically requested by the individual. A family member spoken to express satisfaction with the meals and the provision of alternative options as the needs of their family member changed. Meals sighted at lunch time</p>

		<p>were visually appealing with a range of food choices.</p> <p>Not all foods are stored as required.</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 Low	<p>The care plans described the interventions and services to meet the residents' needs; however, not all interventions shown match what is shown on the assessment and not all care planning intervention updates are supported by assessments. The care plan format includes interventions for the resident's physical, psycho-social, cultural and spiritual needs. Staff demonstrated knowledge of the interventions required for each resident. Residents and family/whānau members reported satisfaction with the care and interventions 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>There are planned activities five days a week, with staff assisting with activities on the weekends. The activities coordinator, who has been in the role for a month, after working as a caregiver at the facility for several years, reports that resident feedback is sought following all activities to ensure the current programme is meaningful to the residents. The activities coordinator has incorporated resident feedback to make some amendments to the activities plan and reported the activities are modified to match residents' capabilities and verbal requests.</p> <p>The documented activities programme changes from week to week and covers physical, social, recreational and emotional needs of the residents. There is a daily physiotherapy programme which is incorporated into individual resident's activities programmes as identified in each of the resident's files reviewed. Evaluation of activities includes the use of attendance sheets and verbal feedback.</p> <p>Residents are encouraged and supported to remain part of the greater community and many go off-site to attend social activities and groups such as craft groups, church functions and coffee outings.</p> <p>Residents confirmed that they enjoyed the activities offered and that their needs are met.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	PA Moderate	<p>Evaluations are recorded on the care plan but they do not describe how the resident is progressing towards meeting their goals. This was an area identified for improvement in the previous audit and remains open. Policy states that where</p>

comprehensive and timely manner.		progress is different from expected the service uses a short term care plan to identify and record these temporary needs. No short term care plans were sighted. The clinical nurse manager confirmed that short term care plans are not being used. Changes are shown in progress notes and discussed at handover as confirmed by staff interviews. Both residents reviewed in detail confirmed changes have been made to their care interventions to meet their current needs. This is supported by family/whānau interviews.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building warrant of fitness expires on 16 June 2016. There have not been any changes to the layout of the building that have required changes to the approved evacuation scheme.
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.	FA	There is monthly surveillance of infections. The service uses standardised definitions appropriate to aged care when determining an infection. All results are analysed and trended by the infection control coordinator (ICC) who is an enrolled nurse. Data is discussed at staff and management meetings. Residents and family/whānau are informed of laboratory results that indicate infection. This is identified in residents' files reviewed and confirmed by resident and staff interviews. The infection surveillance data sighted identifies infections remain stable. The ICC reports that any marked increase in infections would be followed up accordingly. Regular infection control audits are undertaken to ensure staff are following process. One audit identified that disposable gloves were not located in all required areas. This was followed up using the corrective action process which indicates staff education was undertaken and gloves were placed in all areas. A re-audit was conducted and shows the improvement made. The corrective actions were then signed off as completed.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Bed rails and lap belts are the approved restraints in use at the time of audit. These have been consented to by the resident or enduring power of attorney. As part of the internal auditing system, there is an annual review of restraint processes. When enablers are used these are voluntary and the least restrictive option for the resident. All restraints and enablers are used for the safety and comfort of the

		resident. Restraint and enabler use is clearly identified in the resident's file. Staff are aware of the restraint minimising strategies and ensuring enabler use is voluntary and encourages resident independence and safety.
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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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	<p>The medications are supplied by the pharmacy as a pre-packaged medication system. The nursing staff check the medications against the drug chart prior to administration. The prescribers chart medications on admission and review and re-chart the medications three monthly. Medication charts have current photographs of residents attached and allergies recorded. All medication charts viewed had signatures and were compliant with legislation.</p> <p>Safe medication administration was observed during the audit.</p> <p>Each wing has a locked medication trolley and these are kept in a secure room when not in use. The controlled drugs are kept in a locked safe and cupboard and weekly stocktake records</p>	Transcribing of medications and the standing orders do not comply with current legislation and best practice.	<p>Ensure the practice of transcribing cease immediately and all legislation and best practice processes, including standing orders are adhered to.</p> <p>90 days</p>

		<p>were sighted. Medication fridge temperatures are regularly taken and written records are kept.</p> <p>On admission or readmission to the hospital it is common practice for the registered nurses to transcribe medication prescriptions onto the 'pharmacy resident admission need' chart, this is sent to the pharmacy and the drugs dispensed from this for a maximum of three days. These documents are held on the patient's files. Staff were advised that this is not accepted practice and not within the RN scope of practice.</p> <p>Standing orders group multiple medications on one page. The orders are not dated, do not show review date or evidence of audit as required in the medicines standing orders regulations.</p>		
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	<p>The aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines. Storage of some food in the pantry and chiller were not stored appropriately and do not comply with current food safety guidelines. The fridge freezer temperatures are recorded and are within the required control limits. There are sufficient work areas, utensils and cooking facilities for food preparation and service.</p>	<p>Open food bags are stored directly on the floor. Not all decanted food or food in the chiller is dated.</p>	<p>Ensure that food storage complies with food safety requirements.</p> <p>90 days</p>

<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>	<p>PA Low</p>	<p>InterRAI assessments inform the long term care plan which is put in place within three weeks of residents' entering Maygrove Village. The facility has a system in place to show when each resident's ongoing six monthly assessment is due. The six monthly assessments are not up to date. Medical reviews are undertaken to meet timeframes and in the files reviewed the residents had been reviewed medically at least monthly.</p>	<p>Timeframes for ongoing assessments to meet DHB contractual requirements are not being met. For example the RN confirmed that seven of 18 files/residents in one wing of the facility are overdue for assessment. Both residents' files reviewed using tracer methodology had overdue assessments.</p>	<p>Provide evidence that assessment timeframes are met in accordance with contractual requirements.</p> <p>90 days</p>
<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>	<p>PA Low</p>	<p>Not all the interventions shown on residents' care plans are consistent with information found on assessments and in some cases updated care plans are not informed by updated assessments. When questioned staff can verbalise each resident's required interventions to ensure their needs are met.</p> <p>Examples of inconsistencies included the two residents who were reviewed in detail using tracer methodology. In one case the resident's care plan showed that weekly weighs were required but assessment and progress notes showed that this is now monthly. In the other case, the care plan identified that mental health services had input into care but this has been ceased and mental health services have discharged the resident.</p>	<p>Four of the five files reviewed identified inconsistencies between what is shown on the resident's care plan and information of the assessments. Dates on documented assessments do not always correspond with changes made to residents' interventions.</p>	<p>Provide evidence that the care planning and assessment information is congruent.</p> <p>90 days</p>
<p>Criterion 1.3.8.2</p>	<p>PA</p>	<p>There is a process in place to identify</p>	<p>Documented evaluations are</p>	<p>Provide evidence that the</p>

<p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>Moderate</p>	<p>when evaluations are due. This process is behind schedule. Evaluations are not consumer-focused but task orientated. Therefore current information does not identify when a goal has been achieved, such as a resident who has reached their goal weight and no longer requires weekly weighs but can now be weighed monthly.</p>	<p>reworded to mirror the interventions in place and do not describe or indicate the degree of achievement or response to the support and interventions in place. The progress towards meeting desired outcomes are not shown.</p>	<p>evaluation process indicates the degree of achievement or response that has been made by the resident towards meeting documented goals.</p> <p>90 days</p>
<p>Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA Low</p>	<p>Where progress is different from expected some changes are shown on the care plan. Policy states that short term care plans are used for issues that can be resolved, such as infections. One of the residents' reviewed in detail has had several infections resulting in antibiotic therapy but these are not identified on a care plan. It is identified in progress notes. Wound care plans clearly indicate changes required and larger wounds have pictorial evidence of the healing process.</p>	<p>No recent short term care plans were located in any of the residents' files reviewed, where this would have been appropriate.</p>	<p>Provide evidence that policy is followed related to the use of short term care plans and that all intervention changes are shown on the resident's care plan.</p> <p>180 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.