

Heritage Lifecare (BPA) Limited - Maxwell Care Home

Introduction

This report records the results of a Certification 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: Heritage Lifecare (BPA) Limited

Premises audited: Maxwell Care Home

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 25 January 2022 End date: 26 January 2022

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: 24

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

Heritage Healthcare Limited own and operate Maxwell Lifecare Blenheim. The facility has capacity to take 25 residents, for rest home or hospital level care. All beds are dual purpose. The facility is managed by a care home manager supported by a clinical services manager with support from a regional manager and staff from national office.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the District Health Board (DHB) and Ministry. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff and a general practitioner.

A strength of this organisation is their teamwork and dedication to their residents. One area for improvement was identified during the audit related to the timely completion of resident's long term 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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Residents and their families are provided with information about the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Personal privacy, sexuality, independence, individuality and dignity are supported. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Younger people with disabilities were able to express themselves freely. Staff provided residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

Few complaints are recorded and are managed by the care home manager who also maintains the register.

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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Business and quality and risk management plans included the vision, direction and values of the organisation. These cover, appropriate references to younger people with disabilities who are residents. Reporting of clinical indicators occurs automatically through to the regional manager (RM) and national office, as well as monthly reports on the services provided. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements where identified. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified rated

and mitigated. Policies and procedures support service delivery to all residents, including younger people with disabilities, and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix is challenging but meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

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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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

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 facility meets the needs of residents and was clean and maintained. There was a current building warrant of fitness. Electrical equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible and safe. There are multiple areas provided for residents to meet as a group and smaller areas where residents including younger people with disabilities can sit.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Personalised equipment for residents is well maintained and safely stored in their rooms. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. The service's emergency plan considers the special needs of individuals. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented Heritage Lifecare policies and procedures to minimise the use of restraint, with a registered nurse taking on the lead role. During the audit there were no restraints and four enablers in use. Documentation for a comprehensive assessment, approval and monitoring process with regular reviews is occurring. Use of enablers is voluntary and for the safety of residents. Staff demonstrated a sound knowledge and 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 infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to minimise infections to residents' staff and visitors. The programme is reviewed annually. Specialist infection prevention and control advice is accessed from the general practitioner, laboratory and the organisation's support office when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and 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)
Standards	0	44	0	1	0	0	0
Criteria	0	91	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Maxwell Lifecare has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records (6 May 2021).
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Additional consents were sighted for COVID-19 and flu vaccinations. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The clinical services manager (CSM) provided an example of a family member contacting Advocacy Services for advice, though they chose not to pursue this further.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has visiting by appointment currently due to the COVID-19 restrictions. Family/whānau interviewed stated that they understood the process and reasons and that staff were keeping in touch with them and felt welcomed when they did visit. YPD residents are encouraged to participate in the community, to use public transport and attend events promoting access to family and friends.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints policy meets the requirements of Right 10 of the Code. Residents and family are informed of the process as part of the admission pack. Three means of giving feedback are available; at reception, suggestions, compliments, complaints and feedback forms and a minor concerns book. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that four complaints have been received in 2021, one of which was actually an incident. Actions were documented, through to an agreed resolution. Timeframes for response met the requirements of the Code.</p> <p>Action plans showed any required follow up and improvements have been made where possible. The care home manager is responsible for complaints management and follow up.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
Standard 1.1.2: Consumer Rights During Service Delivery	FA	Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through part of the admission information provided and discussion with staff. The Code is displayed in the reception area and staff room,

Consumers are informed of their rights.		together with information on advocacy services, how to make a complaint and feedback forms.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families, including younger people with disabilities, confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by continuing to attend community events, participation in clubs of their choosing and continuing under the care of their general practitioner (GP) rather than transitioning to the house GP. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually (6 May 2021). Relatives interviewed confirmed they have not seen anyone mistreated or neglected.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support the residents in the service who identify as Māori to integrate their cultural, religious and social needs, values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. The Māori Model of Care 'Te Whare Tapa Wha' guides staff in holistic care for Māori residents. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed such as meal preferences, times for going to bed and getting up and what activities they wished to attend. The resident satisfaction survey confirmed that individual needs are being met.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct (22 July 2021). Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through the organisation's evidence based policies, input from external specialist services and allied health professionals, for example podiatrists, district nurses and older persons health, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the recognition of staff. Staff nominate another staff member and share what quality activity they have excelled in then at the monthly staff meeting a name is drawn and the 'superstar' receives a small gift if they are present at the meeting.</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>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this had not been required as all residents were able to speak English. Residents admitted under the younger people with disabilities (YPD) contract were able to express themselves without difficulty.</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</p>	FA	<p>The Heritage Lifecare Limited (HLL) business plans 2020 and facility specific plan 2021 showed goals, with requirements and measures of success. These are reviewed annually. They outlined the organisation's values and mission statement which were reviewed a few years ago. Planning for younger people with disabilities is reflected in the organisation's patient centred approach. A sample of managers' monthly reports to the national office showed</p>

of consumers.		<p>adequate information to monitor performance is reported including financial, emerging risks and issues.</p> <p>The service is managed by a care home manager (CHM) who holds a management qualification and has held management roles in another related health organisation. The CHM is suitably qualified for the role and have been in the role for just over three years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The CHM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending HLL conferences, attending meetings with the DHB, and access to the New Zealand Aged Care Association newsletter.</p> <p>The facility holds a residential aged care contract with the local DHB for long term hospital level care (18 residents), rest home level care (one resident) and respite care (one resident) and a contract with the Ministry of Health for younger persons with a disability ((YPD) (four residents), who are all over 65 years of age and receiving hospital level care.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the CHM is absent, the clinical services manager carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by another senior RN who is experienced in the sector and able to take responsibility for any clinical issues that may arise. They are supported by another local HLL clinical manager. Staff reported the current arrangements work well.</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>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents and complaints, an audit plan, a regular patient and family satisfaction survey, monitoring of outcomes, clinical incidents/indicators including infections, pressure injury, wounds, restraint use and falls. Monthly resident meetings occur. Residents under the YPD contract are included in the quality data and activities.</p> <p>A number of meetings are held monthly and these include staff, managers, health and safety and quality. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at these meetings.</p> <p>Staff reported their involvement in quality and risk management activities through, audit activities, and are informed by noticeboards in the staff room, meetings and messages in Time Target.</p>

		<p>The care home manager develops corrective action forms to address any shortfalls identified. Examples sighted were restraint audit documentation where not all new staff were completing the paperwork. Quality improvement forms are used to record activities to improve care for residents.</p> <p>Resident and family satisfaction surveys are completed annually by the national office; these include residents under the YPD contract. The survey results are benchmarked with other HLL facilities. The 2021 survey showed that Maxwell Lifecare is inline or above the national average, with a few areas just below and these areas are identified to be worked on going forward.</p> <p>Younger residents have electronic equipment and all necessary aids to help mobility and independence.</p> <p>HLL provide the organisation wide policies, procedures and guidelines and cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process with relevant needs assessment service (NASC) requirements for younger people. Policies are based on best practice and HLL have been working on updating these documents with the majority being current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>There is a HLL risk register, which includes the facility wide risks. The home care manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. There are two health and safety representatives who are known to staff who are undertaking training in this area.</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>Staff document adverse and near miss events related to staff or property on an accident/incident form. The incident would be reviewed by the CHM or clinical service manager (CSM) as appropriate and discussed at the health and safety meeting, where corrective action is taken when required.</p> <p>Resident accidents/incidents are recorded on a form which is then loaded into an electronic system by the CSM and also informs the clinical indicators process, which is available to senior management. An escalation process is in place based on a risk matrix, to ensure high risks are brought promptly to the attention of senior staff. Benchmarking on clinical indicators occurs between the HLL facilities related to these areas.</p> <p>A sample of incidents were reviewed and showed these were fully completed, incidents were</p>

		<p>investigated, action plans developed and actions followed-up in a timely manner. Prompt reporting to family members was seen in the files reviewed.</p> <p>The CHM described essential notification reporting requirements, including to Worksafe for staff injuries, and for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit.</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>HLL have a range of policies and flow charts which cover human resources management. These showed how human resources at national office were supporting facility management. The processes are based on good employment practice and relevant legislation. The recruitment process includes an application form, short listing, visa and referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>All health professionals (nurses, general practitioner, pharmacists, podiatrist, dietitian) have a current annual practising certificate.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period and annually. There was a small number of staff whose annual appraisals had not been able to be completed in 2021 and these have been given dates for completion in early in 2022.</p> <p>Continuing education is planned on an annual basis, including mandatory training and competency requirements. Care staff have either completed or commenced a New Zealand Qualification Authority (there were four commencing training, two on level two, one on level three and five on level four) education programme to meet the requirements of the provider's agreement with the DHB. The facility does not have an assessor for the programme. This is managed by using an assessor from another HLL facility. There are three trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate,</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents.</p>

and safe service from suitably qualified/skilled and/or experienced service providers.		<p>The CSM and CHM are on call afterhours, with staff reporting that good access to advice is available when needed.</p> <p>The facility has had vacancies for two registered nurses (RN), two care staff and a cook for some time. The RN positions have now been filled; one being in managed isolation and the other is in transit on their way to New Zealand. One caregiver is commencing the week following the audit and the other position is still to be filled. The kitchen position is being continually advertised with no suitable candidates to date.</p> <p>Observations and review of the eight week roster cycle confirmed overall adequate staff cover has been provided. Three shifts, some only a few hours, were unable to be filled. This is being managed by the CSM doing six days a week in the three weeks reviewed, working on the floor with the management commitment not being met these weeks. Caregivers staff are doing double shifts, casual caregivers are being used when available and activities coordinators, who are also caregivers, are filling the caregivers positions. This is to the detriment of activities programmes. Kitchen staff were doing double shifts to meet the needs of the residents. Management dashboard reports showed peaks for overtime in recent months, and variance to staff usual hours worked.</p> <p>All RNs have a current first aid certificate, with 24 hour a day RN coverage in the hospital. Care staff reported they were getting tired due to the staffing shortages, and they knew management were doing their best to recruit staff. Residents and family interviewed did not raise concerns about staffing and were happy with the care staff and management.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable,</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Relevant NASC assessments and authorisations for residents admitted under the YPD contract were</p>

timely, and respectful manner, when their need for services has been identified.		<p>completed. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate if family are unavailable. If required, the service prints off an interRAI transfer form and uses the DHBs 'yellow envelope' system to facilitate transfer of the residents to and from acute care services. There were no examples of this happening, but the process was explained. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes.</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>	FA	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription and enters this into the system as a record. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were</p>

		<p>within the recommended range.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There were no residents who were self-administering medications at the time of audit. This option is not made available to residents as there is no lockable storage receptacle in residents' rooms.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (3 December 2021). There were no recommendations made at this time.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Marlborough District Council - current until 11 June 2022. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet residents' nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they</p>

declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. The care home manager keeps a register of those waiting for placement and those declined entry to the service. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools, including a pain scale, falls risk, skin integrity, nutritional screening and oral health, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs. The residents under the younger person with disability contract had equipment suited to their needs.
Standard 1.3.7: Planned Activities	FA	The activities programme has been provided by two activity coordinators who also work as caregivers. Due to staffing issues (refer standard 1.2.8) the implementation of the programme

<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>was often left to care staff to initiate activities left out for residents and documentation was not always current as the activities coordinators were pulled on to the floor to work. The role is changing to have only one activities coordinator who is undergoing the diversional therapy training, and she has been able to complete documentation and has plans to develop the programme. There are some volunteers who come to assist with the programme when visiting restrictions allow.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated by engagement at the time of events and as part of the formal six monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Due to the high acuity of residents, a lot of activities occur one to one to meet the residents' needs. Group activities and events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Discussion is had with the residents to obtain their input into the programme.</p> <p>Those residents diagnosed with dementia have 24 hour care plans developed with activities to deescalate any behaviour issues.</p> <p>Activities and social outings, for residents under the younger people with disabilities contract are appropriate for their age and stage of life.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN using the 'stop and watch' tool.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated, were noted for wounds care. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to district nurses for wound assessment and the speech language therapist. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>HLL have documented policies and procedures for staff to follow for the management of waste and infectious and hazardous substances. Appropriate signage is displayed for the storage of oxygen. There were no large amounts of chemicals stored. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. Spill kits are available in two areas of the facility. Pest control is in place and monitored monthly by the chemical provider.</p> <p>Maxwell Lifecare has personnel protective clothing provisions availability for all staff, including those required for use during the different Ministry levels for COVID-19. Staff were observed using plastic aprons, gloves and face masks appropriately.</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>A current building warrant of fitness 23 July 2022 was publicly displayed.</p> <p>The building is over 30 years old and there are signs of areas requiring some refurbishment work. The CHM is aware of these areas with a business case to national office being completed in 2021, but yet to be signed off. A number of areas are in need of repairs and painting and this is scheduled for the next few weeks. Systems are in place to remedy any immediate issues with the residents' physical environment and the facilities are fit for their purpose.</p> <p>The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with CHM and observation of the environment. The maintenance person has been in their role for a few months and carries out general maintenance and work schedules. The hot water is being monitored and some areas have been above the recommended temperature. The maintenance person is taking steps to</p>

		<p>reduce this and checks the temperature of the area to ensure it is safe for use. The environment was hazard free and resident safety was promoted. Personalised equipment is available for all residents including those under the YPD contract to meet all their mobility and equipment needs.</p> <p>External areas are safely maintained and were appropriate to the resident groups and setting. External sitting areas have shade available. Residents under the YPD contract can access all internal and external areas of the facility.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. They know how to report hazards, and these are discussed at the health and safety meetings and corrective actions if required are undertaken. Residents and family members were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>The majority of rooms (20) have a share toilet and shower room, between two residents, with the rest (four) having ensembles. One room (lavender room), does not have a toilet or a shower. There is a toilet close to the room. The resident has to use a shower room of other residents. The CHM described the process to ensure privacy for the resident and to keep them person warm when moving to and from the shower. This is not ideal; however, the room is used for residents who are receiving end of life care and can be managed with reduced access to the shower. The current patient in this room was suitable for the limited amenities within the room.</p> <p>Toilets are also available near to the dining area, with separate toilet facilities for visitors (three) and separate toilets (two) and showers for staff.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>The rooms are in various sizes with all having adequate personal space to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms were observed to be personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs, including those under the YPD contract. There is consideration of all resident's compatibility.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry. Laundry staff who also undertake the cleaning demonstrated a sound knowledge of the laundry processes, with the appropriate washing cycle being available on the machine. The laundry is small but had a clear dirty/clean flow to allow for the segregation of the soiled linen from the clean linen. Residents interviewed and minutes of resident's meetings showed their personnel laundry being generally managed well with a few issues of clothes not being returned in a timely manner.</p> <p>There is a small designated cleaning/laundry team who have received appropriate training. These staff undertake the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and from training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and the chemical provider reports on performance.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>HLL business continuity plan which helps to ensure business processes can continue in the event of an emergency. A Disaster Recovery Plan also deals with restoration of computer systems to full functionality. Policies, guidelines and flip charts guide facility management and staff in emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency.</p> <p>The service's emergency plan has considered any special needs of YPD contracted clients. The current fire evacuation plan was approved by the New Zealand Fire and Emergency Service on 19 January 2011. A trial evacuation takes place six-monthly, with some disruption of the timing due to COVID-19, the most recent being on 21 December 2021. There was a corrective action developed from this trial which has resulted in the CHM carrying out monthly drills until all new RNs can demonstrate the requirements of the process. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p>

		<p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQs were sighted. Water storage tanks are located around the complex, and there is a generator available from a local hire firm. Torches are also available.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place, with afternoon and night staff undertaking security checks. Doors and windows are locked at a predetermined time and there is outside motion sensor lighting to allow staff to identify any issue around the building. The front door has a call bell system and staff can safely see the person before allowing entry at night or at any time during the COVID-19 stages. There is a personal alarm and security pad at reception which is answered by an external contracted company if activated.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and doors that open onto an outside garden. Heating is provided by heat pumps in residents' rooms in the communal areas. Temperatures of the areas are monitored, and thermometers were seen in various areas of the facility; one recorded 22 degrees Celsius on the day of audit. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Maxwell Lifecare implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the organisation's support office. The infection control programme and manual are reviewed annually.</p> <p>The clinical service manager is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the care home manager, and tabled at the quality committee meeting. This committee includes the care home manager, IPC coordinator, the health and safety officer, and representatives from food services and household management. Information is reported through to regional and national levels on a monthly basis.</p> <p>A QR code is available for scanning and a health declaration form, masks and sanitiser were at the main entrance to the facility. Family members are required to make a booking to visit</p>

		<p>relatives and are required to produce a vaccine certificate under the red traffic light system. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for three years. She has undertaken an online training programme in infection prevention and control as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. A newly appointed regional infection prevention control manager provides support and guidance on the organisation's policies and procedures via a monthly zoom meeting. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in November 2020 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided by the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. The IPC coordinator verified that additional staff education has been provided in response to such events as the COVID-19 pandemic response.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and the information</p>

		around COVID-19 restrictions.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, eye, gastro-intestinal and the upper and lower respiratory tract. The IPC coordinator reviews all reported infections and these are documented and entered into the electronic database. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the quality meeting, staff meetings and the regional infection prevention control coordinator. Data is benchmarked against other facilities within the organisation. Benchmarking has provided assurance that infection rates in the facility are below average for the sector with no urinary tract infections recorded in the last twelve months.</p> <p>There have been no outbreaks at the facility 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>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. HHL have three approved restraints that can be used in their facilities (T - belts, bedrails and fall out chairs). The CSM is the restraint coordinator and provides support and oversight for enabler and restraint management in the facility. They demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities, which is documented in the restraint coordinator's job description. Restraint is used as a last resort when all alternatives have been explored. They maintain the register of enabler and restraint use and these are discussed at the quality and RN meetings.</p> <p>On the day of audit, no resident had restraints in use and there had been no restraint use for some time. Four residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>This was evident on review of the minutes of meetings, files reviewed, and from interviews with staff.</p>

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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 1.3.3.3</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 files reviewed showed assessment, planning, provision, evaluation and review of long term care plans was completed in detail. Personalised and specific medical needs were addressed and evidenced family/whānau input. InterRAI assessments were completed according to the contractual agreement, but long term care plans (LTCPs) were not consistently be developed within the required timeframe. The date of completion was between four and eight weeks. The sample number of files was extended to eight to view completion of LTCP dates. This was observed in residents' files with both recent admissions and older admissions. The clinical manager has raised this through the quality meeting as an area of concern. A plan has been developed going forward to address this shortfall.</p>	<p>Files reviewed showed care planning was occurring; however, seven out of eight files reviewed did not have the long term care plan developed within the required time frames (three weeks).</p>	<p>All long term care plans are developed within three weeks of admission.</p> <p>90 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.