Bupa Care Services NZ Limited - Merrivale Rest Home

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Merrivale Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 25 July 2018 End date: 26 July 2018

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: 62

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

Bupa Merrivale provides rest home, hospital (geriatric and medical) and dementia levels of care for up to 66 residents. During the audit, there were 62 residents.

This surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The facility manager is an occupational therapist with significant health management experience and works full time. She has been in the position since 2016. She is supported by a clinical manager with experience in aged care, who has been in the role since February 2018.

Two of three shortfalls identified as part of the previous audit have been addressed. These were around fridge temperatures and food storage. There is one continued shortfall around care plan interventions.

This audit has identified shortfalls around; adverse event reporting, staff training in dementia care, timeframes, and integration of care.

Consumer rights

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

The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

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

There is a business plan with goals for the service that has been regularly reviewed. The service has a robust, quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work

practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

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

Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the activities coordinator. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

There is a current building warrant of fitness.

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.

The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints or enablers at the time of the audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	2	2	0	0
Criteria	0	37	0	4	2	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the care home manager using a complaints' register. There have been eight complaints since the previous audit. All complaints have been managed in line with Right 10 of the Code and document discussion with complainants. A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered. Residents (three rest home and two hospital) and family members interviewed advised that they are aware of the complaints procedure. Discussion around concerns, complaints and compliments was evident in facility meeting minutes.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There are polices in place around open disclosure. The care home manager and clinical manager confirmed family are kept informed. Relatives (one hospital and one rest home) interviewed stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to residents' health status. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised

		resident should they wish to do so. There is access to an interpreter service as required. An introduction to the dementia unit booklet provides information for family, friends and visitors visiting the facility. This booklet is included in the enquiry pack along with a new resident's handbook providing practical information for residents and their families.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Bupa Merrivale provides hospital (geriatric and medical), rest home and dementia level care for up to 66 residents. On the day of audit there were sixty-two residents including one hospital and two rest home residents receiving respite care. There were 22 of 22 residents in rest home beds, and 25 of 29 hospital residents and 15 of 15 residents in the dementia care beds. A vision, mission statement and objectives are in place. Annual goals for the facility have been determined and are regularly reviewed by the care home manager. A quarterly report is prepared by the care home manager and sent to the Bupa quality and risk team on the progress and actions that have been taken to achieve the Merivale quality goals. The service is managed by a care home manager who is a registered occupational therapist. The manager has experience working in allied health leadership roles with the over 65-year age group within the DHB. She is supported by a clinical manager/registered nurse (CM) who has been in the role since February. The clinical manager has previous experience working as a clinical manager. The care home manager and CM are supported by a Bupa regional manager. The care home manager and CM have maintained over eight hours annually of professional development activities related to managing an aged care service.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	An established quality and risk management system is documented. Quality and risk performance is reported across facility meetings and to the Bupa regional manager. Discussions with the managers and staff reflected staff involvement in quality and risk management processes. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff (three caregivers, two registered nurses, one enrolled nurse, one cook and two activities staff) confirmed they are made aware of any new/reviewed policies. There are sufficient clinical policies/procedures to support rest home, hospital level care and dementia level care. Quality data is entered into the organisational riskman data base where results are benchmarked against quality indicators. There is monthly monitoring, collation and evaluation of quality and risk data. Quality and risk data, including trends in data and results are discussed in the quality and applicable staff meetings (link 1.2.4.3). An annual internal audit schedule was sighted for the service with evidence of internal audits

		occurring as per the audit schedule. Corrective actions are established, implemented and are signed off when completed. There is a robust internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. There is an implemented health and safety and risk management system in place including policies to guide practice. The manager is responsible for health and safety education, internal audits and non-clinical accident/incident investigation. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings. Falls management strategies include assessments after falls and individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around this.
Standard 1.2.4: Adverse Event Reporting 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.	PA Moderate	The service collects incident and accident data on forms and enters them into an electronic register (riskman). The system provides reports monthly. The monthly quality meeting, health and safety meetings, staff meetings, and RN meetings all document that incident and accidents are discussed. However, not all incidents had an incident form. Six incident forms were reviewed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents. The caregivers interviewed could discuss the incident reporting process. The clinical manager collects incident forms, investigates and reviews and implements corrective actions as required. The care home manager interviewed could describe situations that would require reporting to relevant authorities.
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.	PA Low	There are policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Five staff files were reviewed (two RNs (one CNM) and three caregivers). All files contained relevant employment documentation including current performance appraisals and completed orientations. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of rest home, dementia and hospital level care. The caregivers when newly employed, complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their level two-unit standards. Staff interviewed believed new staff are adequately orientated to the service on employment. All the care staff who work in the dementia unit have completed the dementia standards. However, the activities staff member had not

		completed the dementia unit standards. There is an annual education and training schedule being implemented. Opportunistic education is provided via toolbox talks. The planner and individual attendance records are updated after each session. Four of the seven RNs have completed interRAI training. Specific competencies are included according to the role such as medications, wound management, cardiopulmonary resuscitation and syringe driver for RNs. The RNs and clinical manager have access to external training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There are policies in place that determines staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. An RN is available on call weekends and after hours and can contact the clinical manager as required for clinical concerns. The care home manager (an occupational therapist) and the clinical manager/RN are on duty during the day Monday to Friday. There is a RN on duty 24 hours. Each unit has a unit coordinator, the rest home unit coordinator is an enrolled nurse, and the hospital and dementia unit each have an RN unit coordinator. The dementia unit had 15 residents on the day of audit. The AM staffing includes the unit coordinator (RN) or a senior caregiver and one other caregiver, the PM staffing includes two caregivers and the night shift one caregiver. The rest home wing had 22 residents on the day of audit. The staffing included; an enrolled nurse plus two caregivers, the PM two caregivers and one caregiver on nights. The hospital unit has an RN on duty every shift. For 25 residents there were four caregivers in the AM and the PM and one caregiver on nights. Residents and relatives stated there were adequate staff on duty always. Staff stated they feel supported by the RN, and clinical and facility manager who respond quickly to after-hour calls.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The Bupa medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual electronic medication orders with photo identification and allergy status documented. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Short-life medications (i.e., eye drops and ointments) are dated once opened. Fridge temperatures had been monitored and were within acceptable limits. This is an improvement from the previous audit. Education on medication management has occurred with competencies conducted for the registered nurse,

		enrolled nurse and caregivers with medication administration responsibilities. Administration sheets sampled were appropriately signed. Ten medication charts reviewed on the electronic system identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. Anti-psychotic management plans are used for residents in the dementia units when medications are commenced, discontinued or changed. The GP reviews the anti-psychotic management plans at least monthly or earlier and if required, makes a referral to the Psychiatric Older People services. A registered nurse was observed administering medications and followed correct procedures. No residents self-administered medications at the time of audit.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	Bupa policies and procedures are available. The kitchen manager (chef) oversees the food services and is supported by a cook and kitchenhands. The national menus have been audited and approved by an external dietitian. The main meal is served at lunchtime. All baking and meals are cooked on-site in the main kitchen. Meals are delivered in bain maries or hot boxes to the kitchenettes in each area where they are served. The kitchen manager receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. End-cooked food temperatures are recorded on each meal daily. Serving temperatures from bain maries are monitored. Temperatures are recorded on all chilled and frozen food deliveries. Fridges and freezer temperatures are monitored and recorded daily. All foods stored in communal resident food fridges were dated, this is an improvement from the previous audit. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained. The food control plan is in the process of approval. Food services staff have completed on-site food safety education and chemical safety. There is specialised crockery such as lip plates, mugs and utensils to promote resident independence with meals. There are nutritional snacks available in the dementia unit 24 hours. Residents have the opportunity to provide feedback on the menu and food services through the resident meeting, which the chef attends. Meeting minutes are available to the food services team.
Standard 1.3.5: Planning Consumers' service delivery	PA Moderate	Care plans reviewed demonstrated aspects of service integration and input from allied health with exception of one file reviewed. The resident care plans sampled were individualised, however not all care plans

plans are consumer focused, integrated, and promote continuity of service delivery.		included all identified care needs, including challenging behaviour and weight management interventions, this is a continued shortfall from the previous audit. Care plans were amended to reflect changes in health status and were reviewed on a regular basis. The residents in the dementia unit had an activity care plan documented to cover the 24-hour period (link 1.2.7.5). Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Care plans sampled were goal orientated (link 1.3.5.2). The staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently if necessary. There were twelve wounds on the wound logs at the time of the audit. The hospital log included three grade two pressure injuries as well as minor skin tears. The rest home included one grade two pressure injury, one surgical wound and minor skin tears and the dementia unit included one lesion. Assessments, management plans and documented reviews were in place for all wounds. Specialist nursing advice is available from the DHB as needed. Monitoring records sighted (weights, behaviour, food and fluids and turning charts) were consistently completed. Residents and family members interviewed confirmed their satisfaction with care delivery.
Standard 1.3.7: Planned Activities 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.	FA	The service employs four activity coordinators including one, who is a diversional therapist in training. The team are responsible for the planning and delivery of the individual and group activities programme with assistance from staff. Bupa has set activities on the programme calendar with the flexibility to add site-specific activities, entertainers and outings. Activities meet the abilities of the rest home, hospital and dementia residents and are provided over five days a week. The dementia unit has activities provided over seven days with caregivers assisting with the activities out of hours and the weekend. Activities were observed to be delivered simultaneously in the rest home, hospital and dementia unit. Residents in the dementia unit are encouraged (where appropriate) to join in activities in the other areas of the care home (observed). There is an activity programme in place that covers the 24-hour period for residents in the dementia unit. Residents are offered a range of activities including daily walks, word games, a daily exercise programme, bingo, a ‘men’s group’ and a range of community links are maintained. The knitting group donate blankets to the women’s refuge. The family/resident completes a ‘Map of Life’ on admission, which includes previous hobbies, community

		links, family and interests. The individual activity plan is incorporated into the long-term care plan and is reviewed at the same time as the care plan in all resident files reviewed. Residents/family have the opportunity to provide feedback on the activity programme through resident meetings and satisfaction surveys. The activity staff interview each newly admitted resident on or soon after admission and takes a social history. This information is then used to develop a diversional therapy plan, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process (link 1.2.7.5). Participation in all activities is voluntary.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status (link 1.3.3.3). Long-term care plans are then evaluated and rewritten. A written evaluation is also documented in the care plan. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes. The registered nurses interviewed explained the communication process with the GP. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if required.
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 holds a current warrant of fitness. The building has two levels on a sloping site with lift access between the floors. Both levels have outdoor access. There is a retirement village located on the first floor and all care is delivered on the second floor. The wide corridors and rails promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained. There is outdoor furniture and seating and shaded areas. The dementia unit has a safe indoor and outdoor environment with a deck, seating, shade and raised gardens. This is a no smoking site. Electrical equipment has been tested and tagged. Reactive and preventative maintenance occurs. There is a 52-week planned maintenance programme in place. Hot water temperatures are monitored weekly in resident areas and are within the acceptable range.

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 a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Care staff interviewed were aware of infection rates. Systems are in place that are appropriate to the size and complexity of the facility. A flu outbreak during February 2018 was well managed and appropriate organisations informed.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints or enablers at the time of the audit.

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)
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Incidents due to an accident were documented very well and logged into the electronic incident log. There was good evidence that the monthly collation was reviewed, and action plans developed where trends occurred. Pressure injuries did not all have and incident form.	There were four pressure injuries documented though the wound care log including; three at hospital level (two grade two and one grade one) and one grade two in the rest home. The three at hospital level did not have an associated incident form.	Ensure that all pressure injuries are documented as part of the adverse event process. 30 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services	PA Low	All the care staff who work in the dementia unit have completed the dementia standards but not the activities coordinator who completes the assessments and activity plans.	The activities coordinator who works in the dementia unit has been trained to meet the requirements of ARC E4.5 c ii.	Ensure the activity coordinator completes the dementia standards or is a trained in

to consumers.				diversional therapy to meet the requirements of ARC E4.5.cii. 90 days
Criterion 1.3.3.3 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.	PA Low	All residents had an up-to-date care plan documented. Care staff were able to describe the care interventions for each resident. Timeframes have not all been met for interRAI assessments and reassessments.	Two rest home resident files (sample increased) documented that one initial interRAI was not within 21 days and one interRAI reassessment was not within set timeframes. Two hospital resident files documented that the interRAI reassessment were not within set timeframes.	Ensure that interRAI assessments are documented within set timeframes. 90 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	Handover occurs at the end of each duty to maintain appropriate service provision. Progress notes are comprehensively written. Three resident files were reviewed (two as part of the sample and one extra did not evidence any RN input/oversite.	There was no documented evidence that three rest home care plans, wound care plan/assessments, while written by an experienced enrolled nurse had any RN oversight.	Ensure there is evidence of RN oversite in the rest home 90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	All residents' files reviewed included an integrated care plan. Not all care plan interventions were fully documented.	(i)The one dementia resident care plan reviewed referenced behavioural issues, but there were no interventions to manage triggers, behaviour outburst or to manage the environment. (ii) The two hospital resident care plans reviewed did not fully document all interventions to meet assessed needs. (a) one resident had a short-term care plan for weight loss, but there were no specific interventions documented other to inform	(i)- (iii) Ensure that interventions are documented to support all assessed needs. 60 days

			next of kin and monitor. (b) one resident care plan did not document the need for a puree diet (noting that the cook was aware of this). (iii) One rest home resident care plans did not document the need for a high protein diet and did not have accurate information for the use of a splint.	
Criterion 1.3.5.3 Service delivery plans demonstrate service integration.	PA Low	Care plans reviewed demonstrated aspects of service integration and input from allied health with exception of one file reviewed. A physiotherapist is available four hours a week to assist with mobility assessments and the exercise programme.	One resident had a PI, a complicated abdominal wound and stoma whose treatment included oversight by the stoma nurse and district nurse. The related assessments and care guidance completed by the external RN specialists were not available for staff or included in the care plan.	Ensure resident files and care plans reflect service integration 90 days

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, these 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.