

Terrace View Lifecare Limited - Terrace View Retirement Village

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Terrace View Lifecare Limited
Premises audited:	Terrace View Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 28 March 2019 End date: 28 March 2019
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:	52

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
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Terrace View Lifecare Limited provides rest home and hospital level care for up to 63 residents. The service is operated by a private company and managed by a facility manager and a clinical services manager. Residents and families spoke positively about the care provided.

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

This audit has resulted in four areas requiring improvement relating to staffing, documentation, evaluation of care plans and care plan changes. Improvements have been made to cleaning processes, addressing the area requiring improvement at the previous audit.

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.	Green	Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. 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. 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 and mitigated. Policies and procedures support service delivery 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.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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A multidisciplinary team that includes a registered nurse and a physiotherapist, assesses residents' needs on admission. Care plans are individualised, based on a comprehensive range of information. Regular medical reviews by the person's chosen general practitioner are on file. Residents' files reviewed demonstrated that multidisciplinary review and evaluation processes for the care provided are planned and efforts are made to keep the records updated. Service delivery is consistent with the documentation in long term care plans.

The planned activity programme provides residents with a variety of individual and group activities that they may choose to participate in. Community links are maintained with residents going to external events and with community groups visiting.

Safe medicine management systems are in place. Medicines are administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs and personal preferences catered for. Safe food handling processes are implemented. Residents informed they enjoy the meals and that there are adequate options.

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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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.
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The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers and no restraints were in use at the time of 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.
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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	14	0	1	2	0	0
Criteria	0	35	0	1	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The electronic complaints register reviewed showed that four complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The facility manager (FM) is responsible for complaints management and follow up. 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>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</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 supported 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 was rarely required due to all residents able to speak English.</p>

communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The business plan, which is reviewed annually, outlines the purpose, values, scope, direction and goals of the organisation. The documents described annual and long-term objectives and the associated operational plans. A sample of monthly reports to the owners showed adequate information to monitor performance is reported including occupancy, sales, inquiries, deaths, sick leave, staff vacancies, meetings, education, compliance, outstanding issues, complaints and adverse events.</p> <p>The service is managed by a facility manager (FM) who holds relevant qualifications and has been in the role for four years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The FM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing professional development and sector meetings and seminars.</p> <p>The service holds contracts with the district health board (DHB) and the Ministry of Health (MoH) for younger persons with a disability (YPD), respite, complex medical conditions, palliative care and rest home care. Fifty-two residents were receiving services under the contracts at the time of audit. Twenty-four rest home level residents and 21 hospital level. Seven residents under these contracts were private paying. Another seven residents were independent living in the facility's apartments.</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 management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint minimisation.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meeting/quality and risk team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and meeting participation. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed overall satisfaction in all areas with improvement in food service. One staff issue was raised, and this has been addressed.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. There are detailed cleaning routines and staff were aware of and followed these, meeting a previous required improvement. The electronic document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The FM 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.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the owners in the monthly report, and they have access on the electronic system.</p> <p>The FM described essential notification reporting requirements, including for pressure injuries. They advised there has been one notification of a significant event made to the Ministry of Health, since the previous audit. This occurred on the day of the audit and relates to staffing.</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>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes 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>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 and annual period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There are enough trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced</p>	<p>PA Low</p>	<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. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of four weeks of a roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. However, there is a shortage of registered nurses (RNs) and the clinical nurse manager (CNM) has been filling these gaps; this requires improvement. At least one staff member on duty has a current first aid certificate and</p>

service providers.		there is 24/7 RN coverage in the hospital.
<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 electronic system for medicine management 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. On the day of audit, there was good clinical nurse manager oversight of the support workers who were administering medicines. Records sighted confirmed that 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. A pharmacist makes weekly visits and signs in newly packaged medicines and any controlled medicines. All medications sighted were within current use by dates.</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 within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's identity and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP medication review is consistently recorded on the medicine chart. Standing orders are not used and nor are faxed medicine records.</p> <p>Three-monthly reviews are completed by the GP and a registered nurse for each of the three people who self-medicate and on the day of audit these were current. The self-medication process is a compromise due to the physical restrictions of their storage in the resident's room. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors, through the adverse event reporting system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	FA	<p>The food service is provided on site by experienced cooks and kitchen hands and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns. Although review of the menu by a qualified dietitian was marginally overdue on the day of audit, a date in early April had been secured</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>for this to be re-reviewed to confirm that it meets the needs of the older adult.</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 control plan issued by the local council that is valid until 1 February 2020. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan, as are hot food temperatures. 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 consistently accommodated in the daily meal plan. Special equipment, to meet individual resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews 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. The dining room was calm and relaxed during the mid-day meal.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Click here to enter text</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified that the overall provision of 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 'up there with the best available in such facilities'. Care staff confirmed that care is provided as outlined in the documentation for each person. A range of equipment and resources was available, although as mentioned throughout the report, there is a need for more registered nurses to ensure all aspects of residents' care and support are met at the level required and within the expected timeframes.</p>
<p>Standard 1.3.7: Planned Activities</p>	<p>FA</p>	<p>The activities programme is provided by two trained diversional therapists holding the national Certificate in Diversional Therapy. One of the therapists was interviewed and expressed confidence in the activity programme</p>

<p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>while telling stories about residents' involvement.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Individualised activity plans are subsequently developed using a holistic approach. The evaluation and timeframes vary with additional reviews as indicated, but all residents' files reviewed had an evaluation and review report that had been completed within the past six months, even when the support plan had not been evaluated. Participation records were also evident.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to both individuals and groups of the residents. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, informal meetings and satisfaction surveys. Residents interviewed confirmed they find the programme interesting and varied with some expression excitement about the diversity of options. Strong community links are being maintained with regular visits to events and local venues, as well as external groups such as school children and entertainers visiting the facility.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to a registered nurse.</p> <p>The clinical nurse manager plans for normal care plan evaluations to occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the registered nurses are expected to make appropriate changes to the residents' care plans. Examples of short-term care plans were sighted but not all included evidence of reviews occurring, although there was evidence of short-term problems having been transferred onto the long-term care plans. Residents and families/whānau interviewed provided examples of when they had received verbal updates from the clinical nurse manager, and they spoke of previous involvement in evaluation and review processes.</p> <p>Evaluation and review processes were checked during the review of residents' service delivery plans. There were a number of examples of short and long-term care plans not having been reviewed, or the goals and progress formally evaluated, within the expected timeframes. This had become an issue from October/November 2018. Likewise, there were examples of long-term care plans not being updated when changes had occurred for the person. Although corrective actions were raised during the audit to address these issues, it is acknowledged that the service provider had already identified the concerns in an internal audit and a planning document for change was available.</p>
<p>Standard 1.4.2: Facility</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 01 Jan 2020) is publicly displayed.</p>

<p>Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The infection control coordinator reviews all reported infections, and these are documented. 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 clinical manager and owners.</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. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, no residents were using restraints and no residents were using enablers. This was evident on review of the restraint approval group minutes, observation and from interview with staff.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>Observations and review of four weeks of roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. However, there is a shortage of RNs and the CNM has been filling these gaps. The facility has been actively advertising for RNs since November 2018.</p>	<p>There is a shortage of RN staff. The facility has been recruiting for two extra RNs since November without success. While all shifts are covered with an RN, and staffing meets minimum requirements, this is because the CNM often steps in to cover for absenteeism. This leaves the required CNM duties not always being completed including documentation in residents' records.</p>	<p>Ensure there is adequate RN staff to provide safe service delivery.</p> <p>90 days</p>

<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>The overall systems in place for assessment, service planning and evaluation and review processes are comprehensive. Effective documentation provided by a quality consultancy is in use. It was noted during the review of residents' records, both for one of the tracers and some of the extended sample, that there were gaps, or incomplete documents. Examples included overdue interRAI reassessments, overdue evaluation and reviews, inconsistencies between records such as a fluid balance chart in use but no indication of why, short term problems being described in progress notes, rather than in short term care plans and blank multi-disciplinary forms. One person admitted at the end of 2018 still did not have a long-term care plan on file.</p> <p>The manager and clinical nurse manager confirmed during interview that there is currently insufficient registered nurse resource available and some of the required documentation had not been completed within the expected timeframes. This had also been identified in an internal audit of residents' records that had been undertaken by the facility manager, and although an organisational action plan was under development this has not yet been implemented due to difficulties recruiting registered nurses. (Refer Standard 1.2.8)</p>	<p>Documentation related to residents' assessment, planning and evaluation processes is not all being completed within the required timeframes.</p>	<p>Adequate numbers of registered nurses will be available to enable residents' assessment, planning and evaluation processes and documentation is completed within the required timeframes.</p> <p>90 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress</p>	<p>PA Moderate</p>	<p>Frameworks are in place for evaluation and review processes, which are expected to be completed when significant changes occur for a resident or at least six-monthly. A multi-disciplinary team meeting template is available to assist with the evaluation of residents' goals. The clinical nurse manager has a record of due dates for interRAI reassessments, for the evaluations of the level of achievement of personal goals and for care plans. Progress notes are comprehensive and these detail updates of progress with short term problems and long-term care plans. Evaluations of activity plans are being consistently completed at six monthly intervals, with previous reviews completed three-monthly.</p> <p>Evaluations and reviews of care plans due prior to November 2018 were evident in all residents' files reviewed. However, there was no evidence that care plan reviews due after this date had been completed, there were blank multidisciplinary forms on residents' files and staff reported using progress notes to ensure residents' needs were met. There were few</p>	<p>Overdue evaluations mean that the degree of achievement, or response to support and/or interventions, was not always evident in short and long-term care plans that were reviewed.</p>	<p>All residents have documented evaluations and reviews that are current and indicate the degree of achievement or response to the goals, support and/or interventions.</p>

towards meeting the desired outcome.		short-term care plans and one dated November 2018 did not state if the issue had resolved, or if it had been transferred to the long-term care plan . One issue for one resident had reportedly resolved but meantime a similar issue had occurred for the person, although this was not evident in the documentation.		90 days
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	PA Moderate	<p>Progress reports written on each shift are comprehensive and informative. In addition to evaluations and reviews not occurring within expected timeframes, there were examples of service delivery plans not accurately reflecting the current needs of the residents. Fluid balance records were being completed for one person; however, the reasons were not evident in medical or nursing notes and the care plan had not been updated. Records of a GP visit to a resident noted concerns about adverse behaviours that were also noted in progress notes. The behaviour section of the care plan stated there were no concerns and there was no behaviour management plan. There was no short-term care plan found for a person with a scalp infection during the month of the audit. The facility manager and clinical nurse manager attributed these shortcomings to the lack of registered nurse resource available to update this level of documentation.</p>	There were three significant examples found of care plans not being updated to reflect changes in the residents' conditions.	<p>Re-assessments are undertaken, and relevant changes are made to the service delivery plan, when changes to a residents' short and/or long-term needs are identified,</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.