# CHT Healthcare Trust - Onewa

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** CHT Healthcare Trust

**Premises audited:** Onewa Hospital and Rest Home

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

**Dates of audit:** Start date: 12 January 2015 End date: 13 January 2015

**Proposed changes to current services (if any):** This audit included assessing three rooms that have not recently been resident rooms as suitable for either rest home or hospital level care.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 63

# 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 |
|  | 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

Onewa Hospital and Rest Home is a purpose built facility. The service provides care for up to 69 rest home and hospital residents. This audit also included reviewing three rooms on the lower floor that have not been used as resident rooms in recent years that have been assessed as suitable for either rest home or hospital level care. The current occupancy is 28 rest home residents and 36 hospital residents. Onewa Hospital and Rest Home is part of the CHT organisation. The CHT group has strong board and effective governance practices. The manager is a registered nurse who has been in the role for one year. Resident and family feedback during the audit was very positive.

Six of eight shortfalls identified at the previous audit have been addressed. These were around meeting minutes, progress notes, care plans, evaluations, fridge temperatures and refurbishment. Wound management has also been addressed. Improvement continues to be required around monitoring forms and aspects of medication management. This audit identified improvement also required around updating care plans following incidents.

## Consumer rights

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| 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. |

Onewa Hospital and Rest Home practices open disclosure with residents and family reporting they are well informed.

## Organisational management

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| 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. |

Onewa Hospital and Rest Home has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process continues to be implemented and includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Residents and relatives are provided the opportunity to feedback on service delivery issues at six monthly resident meetings, at resident’s focus groups and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents have been collated monthly. Onewa Hospital and Rest Home has job descriptions positions that include the role and responsibilities of the position. There is an annual in-service training programme that has been implemented for the year and staff are supported to undertaken external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing and healthcare assistants, residents and family members report staffing levels are sufficient to meet resident needs.

## Continuum of service delivery

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| 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 were individualised and evaluated six monthly. The resident and family/whanau interviewed were complimentary about the staff and standard of care provided.

The team of four activity co-ordinators provide a seven day activities programme for the residents that is varied, interesting and involves community visitors and outings.

Staff responsible for medication administration complete annual competencies and education. The general practitioner (GP) reviews the medication chart three monthly.

An external contractor prepares meals on site and the menu has been approved by a dietitian. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the food that was provided.

## Safe and appropriate environment

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| 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. |

Onewa Hospital and Rest Home holds a current warrant of fitness. This audit has assessed three rooms on the lower level as suitable for hospital or rest home level residents. The rooms are large and there is an open plan lounge/dining area. There are two toilets, one suitable for residents with mobility issues and one shower. Call bells are alerted in the rest of the facility and staff can respond.

## Restraint minimisation and safe practice

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| 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. |

There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently 12 residents requiring restraints and no residents using enablers. Staff are trained in restraint minimisation and challenging behaviour management.

## Infection prevention and control

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| 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 coordinator is a registered nurse. Infection information is collated monthly. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

## Summary of attainment

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

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| **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 | 16 | 0 | 0 | 2 | 0 | 0 |
| **Criteria** | 0 | 41 | 0 | 0 | 2 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **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 | Information about complaints is provided on admission. Interview with residents inform an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a complaints register. Complaints for 2014 to date were reviewed.  All complaints included investigation, time lines, corrective actions when required and resolutions. Results have been feedback to complainants.  Discussions with residents and family members confirmed that any issues have been addressed and they feel comfortable to bring up any concerns. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Eight incidents/accidents forms were viewed. All eight forms indicated family were informed or if family did not wish to be informed. On interview six of six residents (four rest home and two hospital), four family members (one rest home and three hospital) and six health care assistants, two registered nurses, two activities coordinators and the acting clinical coordinator all stated that family have been kept informed following changes in the residents’ health status. Contact records were documented in all files reviewed.  Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files. A residents meeting occurs six monthly and issues arising from the meeting are fed back to staff meetings. Issues raised generate an investigation and corrective action plan. There is a policy that describes the availability of interpreter services when required.  D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. D16.4b: Family members stated that they are always informed when their family members health status changes. D11.3: The information pack is available in large print and advised that this can be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Onewa Hospital and Rest Home is a purpose built rest home and hospital facility. The service provides care for up to 69 rest home and hospital residents. This includes three single rooms in a refurbished wing on the lower floor that have been assessed as suitable for use for hospital or rest home level residents at this audit. The current occupancy is 28 rest home residents including three on short term respite and 36 hospital residents. Onewa Hospital and Rest Home is certified to provide medical services under the hospital component of its certificate. At the time of the audit, there were no residents under this category of care. Onewa Hospital and Rest Home is part of the CHT organisation. Onewa Hospital and Rest Home has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year and aligns with the CHT operational strategic goals and business plan.  The manager is a registered nurse who has been in the role for one year and has a background in clinical management roles. The clinical coordinator position is currently being recruited for and in the interim a senior registered nurse is acting in this position. The manager and clinical coordinator cover all on-call. The manager has completed on-going training appropriate to the position. |
| 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 | Onewa Hospital and Rest Home has a quality framework that is being implemented. There is a quality assurance plan which includes internal audit, incident collation, infection surveillance and hazard management. Interview with staff inform an understanding of the quality activities undertaken at Onewa Hospital and Rest Home. The service has introduced six quality teams with each having a specific focus area. Each focus group meets monthly and report to the staff meeting. The service also has three ‘focus on care’ (quality improvement) projects being implemented around restraint minimisation, the management of weight loss and continence.  Resident meetings occur six monthly. Annual surveys have been conducted of residents and relatives by an external agency. The survey conducted in November 2013 indicated a high level of satisfaction. Following the results the area manager met with all residents and families around the survey results and then a focus group was held with a smaller group of residents focussing on the area of poorest outcome across the organisation.  D5.4 The service has appropriate policies/ procedures to support service delivery; Policies and procedures align with the client care plans. D10.1: Care of the deceased resident procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary certifications and documentation is completed in a timely manner. D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. D19.2g: Falls prevention strategies such as physiotherapy reviews and instruction around prevention in care plans.  Policies and procedures are in place with evidence of review. Meetings standing agenda items of the programme include audit, infection, incidents, complaints and health and safety. Minutes include timelines, responsibilities and the completion of actions. This is an improvement since the previous audit.  The area manager completes a six monthly internal spot audit covering all areas of the service. All issues found in the 2014 audits have identified corrective action plans and resolutions. Results of audits are discussed in staff meetings.   There is a hazard register that is reviewed annually. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. |
| 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. | FA | The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. Once incidents and accidents are reported the immediate actions taken and interventions to minimise the risk of recurrence are documented. The incidents forms are then reviewed and investigated by the manager who monitors issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and a report is reported to the staff meetings. Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification. Public health were informed promptly of a norovirus outbreak in September 2014. |
| 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. | FA | There are job descriptions available for positions that describe staff roles, responsibilities and accountabilities. All staff have employment documentation including employment contracts, job descriptions, interview records, reference checks and current visas where applicable. The practising certificate of RN’s are current. The service also maintains copies of other visiting practitioner’s certification. Orientation and training records are documented in each of the five staff files sampled.  There is an annual appraisal process in place and appraisals are current in all staff files reviewed.  Newly appointed staff complete an orientation that was sighted in all files reviewed. Interviews with ten healthcare assistants described the orientation programme that includes a period of supervision. Supervision can be extended if needed. The service has a training policy and schedule for in-service education that is implemented. Interview with ten healthcare assistants inform there is access to sufficient training.   D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication and syringe driver. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. All residents and family members interviewed stated that they felt there was sufficient staffing.  A contractor physio attends the facility for eight hours a week.  The roster is able to accommodate for the three extra residents being assessed in this audit. |
| 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. | PA Moderate | Regular medications are dispensed in robotic sachets. An RN checks the regular medications on delivery. All medications are stored appropriately and the storage meets legal requirements and guidelines. RNs complete annual medication competency to administer medications. There are two self-medicating residents and both have current competency assessments completed by the GP.  As required (PRN) medications are dated and timed on administration on the signing sheet. There are special instructions for medication administration as required with the medication charts.  Ten medication charts sampled had photo identification and allergies/adverse reactions noted. There is an improvement required around medication administration and documenting the indication for use of PRN medications. This is a previous shortfall that continues to require improvement. Improvement also continues to be required around medication administration. There was no documented evidence of transcribing and this is an improvement since the previous audit.  D16.5.e.i.2; All 10 medication charts reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed. |
| 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 | An external contractor is contracted to provide meals. All meals are prepared and cooked on-site. There is a four week menu cycle in place that has been adapted to meet individual resident feedback and preferences. The menu has been reviewed by a dietitian. Dietary information forms are completed on resident admission and reviewed six monthly with copies held in the kitchen. The chef is informed of any dietary changes. Dislikes are accommodated with alternative choices offered. Special diets are provided. The chef is responsible for ensuring fortified foods are prepared for residents on the REAP programme. Lip plates and specialised utensils are provided for residents to promote independence at meal times. Fridge and freezer temperatures are taken and recorded daily in all areas. This is an improvement since the previous audit. All foods sighted in fridges, freezers and the pantry is suitably stored.  Snacks are readily available for residents as required outside of kitchen hours.  D19.2; Staff have been trained in safe food handling and hygiene.  The kitchen is able to cater for the three additional residents. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The previous audit identified that initial care plans were not completed on the day of admission and that not all identified needs addressed in the care plan. Five files sampled all had an initial care plan completed on the day of admission, and overall required interventions were documented (link 1.3.6.1). |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | When a resident's condition has altered, the registered nurses have initiated a review and if required, GP consultation. Four relatives interviewed confirm they have been kept informed of any changes in their relative’s health.  Staff interviewed confirmed they have all the equipment referred to in care plans necessary to provide care. Continence products are available and resident continence management plans are completes for residents as applicable.  D18.3 and 4; Dressing supplies are available and there are adequate supplies of other medical equipment. Wound assessments and treatment plans are in place for 16 wounds; including four pressure areas. All have been reviewed in the stated timeframes. These are improvements since the previous audit.  Resident weight is recorded on admission and monitored monthly. Weight loss reports have been completed for any resident with weight loss. Residents with weight loss have been commenced on the REAP (replenish energy and protein – food fortification) intervention therapy. Fluid balance charts have been initiated when needed and the two sampled were up to date and accurate. This is an improvement since the previous audit. |
| 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 a team of activity co-ordinators to implement a seven day week activity programme. There is an integrated rest home/hospital activity programme with activities that are rotated to occur in the lounges of each suite. Attendance at activities are voluntary. The activity co-ordinators make daily contact with residents who are unable to participate in activities or choose to stay in their rooms. Community volunteers including a local school visit regularly. There are outings at least fortnightly.  Resident meetings and surveys provide residents with an opportunity to feedback on the activity programme. Each month the service focusses on a different culture. Residents and the family confirm on interview they are involved in the development of the care plan which includes activities. The activity co-ordinators maintain an individual activity attendance sheet. Residents and relatives interviewed are satisfied with the content and variety of the activity programme.  D16.5d: The review of the activity plan and care plan occurs at the same time. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial assessments and initial care plans are developed by a RN within 48 hours of admission. The long term care plan is evaluated at least six monthly in four of five resident files sampled (one resident is on short term respite care). Six monthly evaluations identify if the resident goals have been met or unmet. Care plans are updated with changes following care plan evaluations.  ARC: D16.3c; Initial care plans are evaluated by the RN within three weeks of admission for four of five files sampled. |
| 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 Onewa Hospital and Rest Home facility holds a current warrant of fitness.  There is easy and safe access for residents from bedrooms to internal communal areas. Outdoor areas are safe to access and there is seating and shade provided. Hallways are sufficiently wide enough to allow residents to mobilise with the aid of walking frames safely and other mobility aids.  The service has undergone a refurbishment in three wings since the previous audit.  Reactive and preventative maintenance occurs. Electrical equipment has been checked and tagged. All clinical equipment has been checked/calibrated annually. Resident hot water temperature checks are carried out monthly with stable temperatures at 43-45 degrees Celsius.  This audit has assessed three rooms on the lower level as suitable for hospital or rest home level residents. The rooms are large and there is an open plan lounge/dining area. There are two toilets, one suitable for residents with mobility issues and there is one shower for the three rooms. Call bells are alerted in the rest of the facility and staff can respond.    ARC D15.3; There is adequate equipment available for the rest home and hospital. Interviews with staff confirmed there was adequate equipment. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | As the three new rooms have previously been resident rooms and already included in the fire evacuation scheme, the New Zealand Fire Service approved evacuation scheme issued in June 2001 does not require amendment. |
| 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 | Infection monitoring is the responsibility of the infection control coordinator. The surveillance activities at Onewa Hospital and Rest Home are appropriate to the acuity, risk and needs of the residents.  The infection control coordinator enters infections on to the infection register and carry out a monthly analysis of the data. The analysis is reported to the staff meeting and the RN meeting. The infection control coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of G.P involvement and laboratory reporting. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Staff were familiar with the policy and the definition of enablers. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective.  The restraint manual determines that enablers are voluntary and the least restrictive option. There are no enablers in use in the facility and 12 residents with 14 restraints. |

# 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 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Ten medication charts sampled have been reviewed by the GP and all sachet medications have been signed as administered as prescribed. The GP interviewed is aware of the appropriate prescribing requirements for as required (PRN) medication. | (i) Three of ten medication charts sampled have non packaged regular medications that have not been signed as administered as prescribed. (ii) Three of ten medication charts sampled have PRN medications prescribed with no documented indication for use. | (i) Ensure medications are administered as prescribed. (ii) Ensure all PRN medications have a documented indication for use.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | There are monitoring forms available for pain monitoring, fluid balance, intake, hourly checks, two hourly turns and restraint use. Two fluid balance charts, one of two fluid balance charts, two hourly checks forms, two of three restraint monitoring and two of two hourly check forms are up to date and accurate. | (i)Two of eight incident forms sampled have detailed changes to care following the incident. These interventions have not been documented in the care plan. (ii) One of two, two hourly turning charts and one of three restraint monitoring forms have at least one day in the past week where monitoring has not occurred for an entire shift | (i) Ensure that care plans are updated when changes to care requirements are documented on instant forms. (ii) Ensure monitoring occurs when required and that this is documented  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.

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End of the report.