

Wharekaka Trust Board Incorporated - Wharekaka 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 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:	Wharekaka Trust Board Incorporated
Premises audited:	Wharekaka Rest Home
Services audited:	Hospital services - Medical services; Rest home care (excluding dementia care)
Dates of audit:	Start date: 17 October 2017 End date: 17 October 2017
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:	20

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

Wharekaka Rest Home Incorporated provides rest home and hospital level care for up to 20 residents. The service is operated by the Wharekaka Trust Board and managed by a general manager and a clinical services manager. A partial provisional audit was conducted last year in response to a request to be able to provide hospital level care. The service now has a contract to provide this service. 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, the trust board chairperson and a general practitioner.

This audit has resulted in one area requiring improvement relating to care planning. Improvements have been made to staff training, review of policies and procedures, registered nurse (RN) recruitment, obtaining an updated fire evacuation plan, corrective action planning and infection prevention and control, addressing those areas requiring improvement at the previous certification and partial provisional audits.

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.



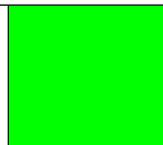
Standards applicable to this service fully attained.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required.

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.



Standards applicable to this service fully attained.

Business and quality and risk management plans include the philosophy of care and core values of the organisation. Monitoring of the services provided to the governing body is regular and effective. A non-clinical general manager is supported by the clinical nurse manager in the management of the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. An internal audit programme is in place. Staff are involved in quality improvement activities 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 are now current and reviewed regularly.

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

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

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

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

The organisation uses an electronic medication management system. Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Menus are reviewed by a qualified dietitian. Residents verified satisfaction with meals.

Safe and appropriate environment

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

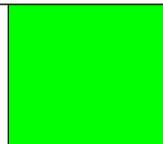


Standards applicable to this service fully attained.

There is a current building warrant of fitness and an updated fire evacuation plan has been approved.

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.

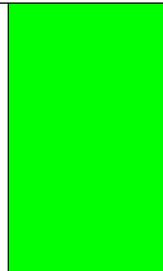


Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler and three restraints are 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.

The infection prevention and control programme aims to prevent and manage infections. The clinical nurse manager holds the infection prevention coordinator role and undertakes relevant training annually. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed. There is a range of infection prevention and control systems in place.

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

Aged care specific infection surveillance is undertaken, and results reported through staff meetings and the trust board. Follow-up action is taken as and when required and was evident in meeting minutes.

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	17	0	0	1	0	0
Criteria	0	41	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>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. Forms are available in reception where a suggestions and complaints box is also located.</p> <p>The complaints register reviewed showed that one complaint has been received over the past year and that action taken, through to an agreed resolution, was well documented and completed within the timeframes. The general manager 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</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their or 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 know how to access interpreter services which are available through the Wairarapa DHB, however the service reported this was rarely required due to all current residents able to speak English and the rural community served by the facility being predominantly made up of New Zealand Europeans.</p>

environment conducive to effective 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 strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The new five year strategic plan had been signed off by the board in the month before audit. The documents reviewed described annual and longer term objectives and the associated operational plans. A sample of monthly reports to the board of trustees showed detailed information to monitor performance is reported including financial performance, emerging risks and issues and staffing. The board chairperson reported she meets on a weekly basis with the general manager to discuss any matters that may arise and reports communication and information flow from her is excellent.</p> <p>The service is managed by a general manager (GM) who holds relevant qualifications and has been in the role for ten years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The GM confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through regular networking, business and quality seminars as well as on going involvement with the New Zealand Aged Care Association. The clinical nurse manager (CNM) has had experience in working in the aged care sector for a number of years.</p> <p>The service holds contracts with the DHB for residential aged care, health recovery, respite and palliative care. Twenty residents were receiving services under the contract, six hospital level and 14 rest home level care at the time of audit. No residents are currently receiving care under the palliative care, respite or health recovery contracts.</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 resident satisfaction survey, monitoring of outcomes, clinical incidents, including infections, and health and safety.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed with the management team, at monthly governance and staff meetings. Staff reported their involvement in quality and risk management activities through the internal audit activity and the regular discussions at staff meetings. Relevant corrective actions are now being regularly developed and implemented to address any shortfalls that are identified through the internal audits and quality reporting process. Resident and staff meeting minutes now record progress on any corrective actions and sign off when these are completed. Resident and family satisfaction surveys are completed annually. The most recent survey showed there was concern about the lack of room in the van providing transport planned for outings. This has been addressed with the purchase of a second van that is also able to accommodate wheelchair users, which has alleviated the concerns.</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. These have also been updated to reflect</p>

		<p>the requirements for the provision of hospital level care. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The GM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The GM 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>	FA	<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. An electronic system in use provides graphs and summaries of the clinical indicators. All adverse event data is collated, analysed and reported to management, staff and monthly to the board. Records reviewed showed the recording of incidents followed the facility process and that families were also notified as required.</p> <p>The GM described essential notification reporting requirements, including for pressure injuries. She advised there has been one notification of a significant event made to the Ministry of Health since the previous audit. This was reviewed and evidenced the required process was followed.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>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 show documentation of completed orientation and a performance review after a three-month 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. A staff member is currently training to be an internal assessor for the programme. The facility currently shares resources with another local trust who have an internal assessor to provide support. Training has now been completed in dementia care, respiratory services and palliative</p>

		care for clinical and care staff to meet the requirements for the provision of hospital level care. There are sufficient 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>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented policy and procedure for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The CNM completes the rosters and adjusts staffing levels to meet the changing needs of residents. This is informed by acuity levels of current residents and feedback from staff. 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; however, they reported the requirement to also do facility laundry does put additional pressure on staff. The outsourcing of this is currently being investigated by the GM. Residents and family members interviewed reported staff are always readily available. Observations and review of a two-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24//7 RN coverage in the hospital as is required by their new contract for the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's electronic authorisation signature and date recorded on</p>

		<p>the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. The facility does not use any standing orders.</p> <p>There were no residents self-administering medications at the time of audit. Processes are in place to follow for residents who wish to self-administer medications.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a full time cook and a weekend cook and is in line with recognised nutritional guidelines for older people. The menu follows a summer and winter patterns and was last reviewed by a qualified dietitian in April 2017 (sighted).</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan dated February 2016. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a New Zealand Qualification Authority (NZQA) safe food handling qualification and undertakes inhouse training, including infection control.</p> <p>A dietary profile is undertaken for each resident on admission to the facility and the personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The kitchen caters for a range of dietary requirements including diabetics and soft diets. Special equipment such as lipped plates, is available to meet resident's nutritional needs.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, the six-week follow-up audit, annual satisfaction surveys and informal feedback. Residents interviewed expressed satisfaction with the meals provided and acknowledged that their individual preferences were accommodated. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided by staff.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their</p>	PA Moderate	<p>Documentation, observations and interviews verified the provision of care provided to most 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 most of the areas of service provision. There is minimal documentation of interventions to meet some resident's needs and desired outcomes. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was mostly provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>

assessed needs and desired outcomes.		
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by a diversional therapist who is assisted by a volunteer and the Trust Auxiliary.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. There is a full and varied activities programme in place which is appropriate to the level of participation from residents. Individual, group activities and regular events, such as, pilates, van outings, quiz, newspaper readings are offered. On the day of audit residents were observed being actively involved with a variety of activities. Residents and families/whānau are involved in evaluating and improving the programme through the six-week follow-up audit, annual satisfaction surveys and informal feedback. Residents and families interviewed voiced their satisfaction for the activities programme and felt that recreational needs were being met.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Care plans reviewed had been evaluated at least every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service does not show response by initiating changes to the plan of care (Refer criterion 1.3.6.1). Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for urinary tract infections, respiratory tract infections, wounds, and wandering behaviours. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	FA	<p>A current building warrant of fitness (expiry date 30 June 2018) is publicly displayed.</p>

for their purpose.		
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>An updated approved evacuation plan dated 19 December 2016 was sighted. This was required following the move to provide hospital level services.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme, recently developed, to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from an external provider. The infection control programme and manual are reviewed annually.</p> <p>The clinical manager is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the infection control committee, the general manager, and the Trust board (results and reports sighted). This infection committee includes the IPC coordinator and two other care staff.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell.</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</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, eye, fungal, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plans 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 (reports sighted). 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 this is reported to the IPC committee, the general manager and the Trust board. Data is benchmarked externally with other aged care providers. Benchmarking has provided assurance that most infection rates in the facility are below average for the</p>

control programme.		<p>sector.</p> <p>A summary report for a recent shingles infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up including consultation with the infection control team from the DHB. Learnings from the event have been discussed with staff and are being incorporated into practice, with additional staff education implemented.</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, three residents were using restraints and one residents was using an enabler, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the three monthly restraint approval review group minutes, files reviewed, and from interviews 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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>In two out of five care plans reviewed did not demonstrate interventions to meet all assessed residents' needs. For example, one hospital resident (refer 1.3.3) did not have interventions documented in sufficient detail for the management of a high-pressure injury risk and a current pressure injury in place. One rest home resident (refer 1.3.3) with a significant medical condition, did not have interventions documented in sufficient detail to guide the care staff in the care plan. Despite this staff interviews reflected awareness of interventions required to meet the assessed needs.</p>	<p>Although there are identified assessed needs, the interventions in the care plans are not consistent with nor contribute to meeting the residents' needs. In the files sampled, two of the five care plans had not been updated following a change in health condition, and not all interventions for assessed care needs were being documented or documented in sufficient detail to guide the care staff.</p>	<p>Ensure that interventions are documented for all assessed care needs, in sufficient detail to guide the care staff, and that all interventions in use are documented.</p>

				90 days
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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.