

# Trinity Home and Hospital Limited - Trinity Home & Hospital

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## 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 Q-Audit 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:

<b>Legal entity:</b>	Trinity Home and Hospital Limited
<b>Premises audited:</b>	Trinity Home & Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 11 July 2018    End date: 12 July 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	63

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

## General overview of the audit

Trinity Home and Hospital (Trinity) is owned by the Trinity Trust which is a registered charity. Governance is the responsibility of the Trinity Board of Directors. The service provides rest home, hospital medical and geriatric and secure dementia care services for up to 78 residents. The general manager (GM) is responsible for the management of the facility and is supported by the clinical manager, clinical nurse manager and a resource manager.

The unannounced surveillance audit was conducted against a sub set of the health and Disability Services Standards and the service's contract with the District Health Board (DHB). The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family and management, staff, contracted allied health professionals and a general practitioner.

Residents and families spoke positively about the care provided.

This audit has resulted in three of four areas identified as requiring improvement from the previous audit as being addressed and one area in relation to evaluation and updating of care plans remains open. There was one area requiring improvement identified during the audit. There have been no changes since the last 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.		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 formal interpreting services if required.

The general manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been 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.
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Trinity Trust is the governing body and is responsible for the service provided at this facility. A business, quality and risk management plans are documented. Systems are in place for monitoring the services provided.

The facility is managed by an experienced and suitably qualified manager. A quality and risk management system is in place. Collection, collation and analysis of quality improvement data is occurring. Discussion of trends and follow up where necessary occurs. Adverse events are documented and are seen as an opportunity for improvement. Corrective action plans are being developed, implemented, monitored and signed off. Informal and formal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated and the hazard register is up to date.

A suite of policies and procedures cover the necessary areas and are current and reviewed regularly.

The human resources management policy guides the system for the recruitment and appointment of staff. An orientation and staff training programme ensures staff are competent to undertake their role. A systematic approach to identify, plan and facilitate ongoing education supports safe service delivery. Appraisals for staff are performed annually. Registered nurses are encouraged to undertake post graduate study relevant to their role.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. There is a roster of senior staff on call out of hours.

## 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 low risk.</p>
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Care plans and assessments sampled are completed by the nursing team within the required time frames and demonstrate service integration. Resident centred care plans are reviewed every six months and short term care plans are consistently developed when acute conditions are identified. 24-hour dementia diversional care plan was sighted in all care plans in the dementia unit.

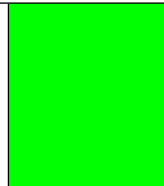
Planned activities are appropriate to the residents' needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

The meal service meets the individual food, fluids and nutritional needs of the residents. Residents with special dietary needs are catered for.

A safe medication management system is in place and meets legislative guidelines and policy requirements. Medication is administered by staff with current medication competencies. All medication charts are reviewed by the GP as required.

## 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.

All building and plant complies with legislation and a current building warrant of fitness was displayed.

## 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. No enablers and no restraints are in use at the time of audit. Restraint is only used as a last resort when all other options have been explored. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes. Environmental restraint is used for the secure dementia service.

## 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 type of infection surveillance is appropriate to the size and complexity of the service. Infection statistics are collected, recorded, analysed and reported to staff and management. All actions or recommendations to lower infection rates are discussed in staff meetings and reports compiled.

## 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)
<b>Standards</b>	0	16	0	1	0	0	0
<b>Criteria</b>	0	42	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>	<p>FA</p>	<p>The complaints policy has been reviewed. The policy and associated forms reviewed meet the requirements of Right 10 of the Code. The information is provided to residents and family as part of the admission process. There is complaints information and forms available in all service areas and at reception.</p> <p>The complaints register is maintained. Complaints are a standing agenda item for staff and management meetings. All complaints are reported to the Board.</p> <p>The complaints register reviewed showed that 16 complaints have been received over the last eighteen months since the previous audit and that actions were taken through to an agreed resolution were documented and completed within the timeframes specified in the Code. All complaints were effectively closed.</p> <p>The general manager is responsible for the complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their relative's status and 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. There was also evidence of resident/family input into the care planning process. Staff interviewed understood the principles of open disclosure which is supported by policies and procedures that meet the requirements of the Health and Disability Services Consumers' Rights (the</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>Code).</p> <p>Interpreter services are able to be accessed via the district health board (DHB) when required. A Maori health advisor is available at the local hospital if required. Staff knew how to do so although reported this was rarely required due to most residents being able to speak English and staff are able to provide interpretation as and when needed.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The strategic and business plans which are reviewed annually by the board outline the purpose, values, philosophy, scope and objectives of the organisation. The documents reviewed describe annual and longer term objectives and the associated operational plans. The general manager (GM) provides monthly outcome reports against the objectives to the board. The board of directors consists of seven members and six members are on the trust board. There is a diverse representation of members of the community on the board. Meeting minutes were sighted.</p> <p>The quality plan sighted described how the organisation's goals are monitored and evaluated by the GM and the management team to ensure the needs of the residents are being effectively met. An organisation flow chart was reviewed with the residents as the central focus.</p> <p>The GM has been in this role for ten years and maintains ongoing education to the role. The GM is suitably skilled and experienced for the role and has responsibilities and accountabilities defined in a job description and individual employment agreement. The GM interviewed confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency by attending liaison meetings at the DHB. The GM is supported by the clinical manager who has delegated management and clinical responsibilities and the resource manager who provides management support. All staff maintain the required education for the role they undertake. Five registered nurses have interRAI competencies.</p> <p>The service holds contracts with the DHB for rest home, secure dementia, hospital – medical/geriatric and respite care. On the day of audit there were 63 beds occupied consisting of 21 rest home, 19 secure dementia, nil respite and 23 hospital level residents. There is a total of 19 swing beds that can be used for rest home or hospital level care. An additional four beds are allocated for the dementia care service for respite care if needed.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>FA</p>	<p>The organisation has a quality and risk system that reflects the principles of continuous improvement and is understood by staff. This includes management of incidents and complaints, audit activities and a regular satisfaction survey, monitoring of outcomes, clinical incidents and this includes restraint minimisation and infection prevention and control.</p> <p>Terms of reference and meeting minutes reviewed confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs and related information is discussed at the quality/management team/staff meetings. Staff reported their involvement in quality and risk activities through</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>assisting with internal audits which have been designed to add value and improve Trinity's clinical operations. Relevant corrective actions are developed and implemented as necessary and demonstrated a continuous process of quality improvement. Resident and family surveys are completed annually. The last survey in 2017 sighted no themes of dissatisfaction had been raised.</p> <p>The service has a risk management register which covers all aspects of service delivery. A risk matrix is used to categorise any identified risks. The identified risks are monitored by the GM and the board. Monitoring frequency is decided according to the risk rating. All hazards are monitored as part of the health and safety programme. Staff are informed of any new hazards identified and residents as applicable. Staff interviewed confirmed they understood and implemented the hazard identification processes. Actions taken are reported in the health and safety minutes reviewed. The GM and the clinical manager are fully aware of the Health and Safety in Work Act (2015) requirements and these are implemented.</p> <p>Staff/family/whanau and resident interviews confirmed any issues were addressed by management.</p> <p>Policies and procedures reviewed cover all necessary aspects of the service and contractual requirements are documented. All policies and procedures have been reviewed and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval and distribution occurs. Policies and procedures are accessible for all staff. Obsolete documents are removed and stored appropriately in the archives room. All records are filed to ensure they can be retrieved if needed. Records are stored for 10 years as required and then are disposed of by a contracted provider.</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>Adverse event reporting is described in policy. The clinical manager confirmed a good knowledge of the statutory and or/regulatory obligations required. The clinical manager advised that there have been no significant incidents and/or infection outbreaks since the previous audit.</p> <p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed show these are fully completed, incidents are investigated, action plans developed and actions are followed up in a timely manner. Adverse event data is collected separately for the dementia service and the rest home and hospital are collated together. Staff meeting minutes sighted show discussion occurs in relation to any trends identified, action plans put in place and improvements made.</p> <p>The previous area requiring improvement has been addressed.</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>Policies and procedures are in line with and identify human resource management which meets legislative requirements. Position descriptions were current and defined key tasks and accountabilities for the various roles. The recruitment process includes, referee checks, police vetting and validation of qualifications, competencies and annual practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained.</p> <p>Staff orientation includes all necessary components relevant to the role and meets the requirements of the service provider's contract with the DHB. Staff reported that the orientation processes prepared them well for their role and included support from a 'buddy' through the initial orientation period. Staff records reviewed show documentation of completed orientation and a performance review after 90 days. There are nine registered nurses employed to cover the services. The registered nurses have competencies to be completed specifically for their role including professional responsibilities, management of nursing care, interpersonal relationships, and inter-professional health care and quality improvement.</p> <p>Continuing education is planned annually. Mandatory training requirements are defined and scheduled to occur over the course of the year. Records are maintained by the clinical manager. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. All staff working in the dementia care area have completed the required education. Education records reviewed demonstrated completion of the required training. Staff reported that the annual performance appraisal process provides an opportunity to discuss individual training needs, supervision requirements and review competencies. Appraisals were current for all staff.</p> <p>The previous area requiring improvement has been addressed.</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 service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The clinical manager and clinical nurse leader adjust staffing levels to meet the changing needs of residents. Rosters reviewed show that staff levels exceed the contractual requirements for all shifts covering the twenty four hour period. There is evidence that staff are replaced for annual and sick leave as needed. The minimum number of staff is provided during the night shift and consists of four caregivers and one registered nurse. There is an on-call roster sighted for the after-hours and staff reported that good access to advice is available when needed. Care staff reported adequate staff were available and they were able to complete the work allocated to them. This was further supported by residents and family interviewed. Observations and the rosters sighted confirmed adequate staff cover has been provided. At least one staff member on duty has a current first aid certificate and there is 24 hour registered nurse cover for the hospital.</p> <p>The GM, clinical manager, clinical nurse leader and resource manager work 40 hours per week Monday to Friday. In addition to nursing and care staff there are dedicated cleaning, laundry, kitchen, diversional/activities therapists and</p>

		other contracted health providers as needed.
<p><b>Standard 1.3.12: Medicine Management</b></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 system complies with current legislation, protocols, and guidelines. Residents receive medicines in a safe and timely manner. All medications are reviewed three monthly or as required by the GP. Allergies are clearly indicated, and current photos uploaded for easy identification. When per rising need medication is administered appropriate documentation is completed.</p> <p>The medication and associated documentation are stored safely, and medication reconciliation is conducted by RNs when a resident is transferred back to service. The service uses pre-packaged packs. There were no expired or unwanted medications. Expired medications are returned to the pharmacy in a timely manner. Controlled drugs are stored securely in accordance with medicine management system requirements. Controlled drug register is current and correct. Weekly and six-monthly stock checks are conducted. Imprest stock is stored securely and regular monitoring of stock is maintained.</p> <p>An annual medication competency is completed for all staff administering medications and medication training records were sighted. The RN was observed administering medication safely and correctly. There were no residents who self-administer medications at the time of the audit. Self-administration policies and procedures are in place if required. The previous area requiring improvement has been addressed.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></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>Meal services are prepared on site and served in the allocated dining room. The service employs two cooks and provides meals on wheels to the community. The kitchen has been registered with the local council under the food control plan. The menu has been reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. There is a four-weekly rotating winter and summer menu in place.</p> <p>The residents have a dietary assessment completed on admission which identifies nutritional requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness on dietary needs required by the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues.</p> <p>The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is completed.</p> <p>The residents and family interviewed acknowledged satisfaction with the food service. Snacks and drinks are available for residents who wake up during the night on a 24 hour period.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans are resident centred, integrated and provide continuity of service delivery. The assessed information is used to develop long term and short term care plans for acute needs. Goals are specific and measurable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled are integrated and included input from the multidisciplinary team. The residents and relatives interviewed confirmed care delivery and support is consistent with their expectations and plan of care. All care plans sampled included detailed interventions to meet the resident's current health status.</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>The documented interventions in short term and resident centred care plans are sufficient to address the residents assessed needs and desired goals/outcomes. Any changes are reported in a timely manner and prescribed orders carried out as confirmed by the GP. Progress notes are completed on every shift. Adequate clinical supplies were observed and the staff confirmed they have access to enough supplies. Residents and family/whanau members interviewed reported satisfaction with the care and support they are receiving.</p>
<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>	<p>FA</p>	<p>There is a full range of social activities that are available on the weekly programme for all residents to participate in. All residents are assessed and invited to participate in specific activities that are appropriate for their level of ability and interests. The activities are used to facilitate emotional and physical wellbeing. The activities can either be individual or group activities conducted under the guidance of the two diversional therapists who share the work load. There were documented evaluations on the residents' participation and the outcomes that residents are achieving from these. The activities provided are individualised to meet the needs for people living with dementia. A dementia clock is developed for all residents living with dementia outlining diversional activities on 24 hour period.</p> <p>The residents were observed participating in a variety of activities on the audit days. Residents were observed going offsite with family/friends and with several community organisations providing activities at the service. There are planned activities and community connections that are suitable for the residents. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided. Activities plans are evaluated every six months but were not consistently linked to InterRAI assessments (refer standard 1.3.8).</p>
<p>Standard 1.3.8: Evaluation</p>	<p>PA Low</p>	<p>Family/whanau and staff input is sought in the review of care plans. Short term care plans are evaluated by the nursing team and resolution of acute conditions are documented. The previous area of non-conformance has been</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>addressed.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness 3 December 2018 is publically displayed. The last fire drill was held on the 14 June2018.</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>	<p>FA</p>	<p>A surveillance programme has been implemented and documented. Infection surveillance practice, activities and outcomes are well documented and supported with evidence of compliance sighted. Recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated and reported in a timely manner. The RN oversees the programme and staff are informed of surveillance outcomes. An infection report is completed and infections are signed off when resolved. Antibiotic usage is monitored through infection reports. Infection register was sighted and is completed monthly. Hand washing audits are completed annually. An infection control annual report was completed. There were no infection outbreaks reported since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers. The clinical manager interviewed provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures, practice and responsibilities.</p> <p>On the day of audit no residents were using restraints and no residents were using enablers. Processes are in place if either are in use.</p> <p>Restraint is used as a last resort when all alternatives have been explored. Environmental restraint is monitored for the secure dementia service. De-escalation training is provided for staff for managing residents who may present</p>

		with challenging behaviour. The restraint process is reviewed annually.
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	<p>Some files sampled had been evaluated before InterRAI assessments were completed. Care plans are evaluated every six months or as required. Reviews are documented and include current residents' status and any changes and achievements towards goals.</p>	<p>Resident centred care plans and activity plans are not being evaluated in conjunction with InterRAI assessments.</p>	<p>Provide evidence that care plans are evaluated in conjunction with InterRAI assessments.</p> <p>180 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.