

Whangaroa Health Services Trust - Whangaroa Health Services

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Whangaroa Health Services Trust
Premises audited:	Whangaroa Health Services
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 5 August 2019 End date: 5 August 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	25

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

Whangaroa Health Services Trust operates a community owned primary health care service and an aged residential care service. The Kauri Lodge aged care service has 25 beds and provides rest home and hospital (geriatric and medical) level care. On the day of the audit there were 25 residents. An interim general manager oversees operations of the health service, which includes the medical centre and the Kauri Lodge.

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

The service has addressed seven of nine shortfalls from their previous surveillance audit around communication, quality improvement data and corrective actions, first aider on duty at all times, activities plans, hot water monitoring and infection control. Further improvements continue to be required around education and interRAI timeframes.

This surveillance audit identified improvements are required around wound care documentation and short-term care plan evaluations.

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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Residents and family interviewed, and documentation sighted verified ongoing involvement with the community and evidence of open disclosure. Complaints processes are implemented and managed in line with the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A clinical manager/registered nurse (RN) is responsible for the day-to-day operations of the facility. Quality and risk management processes are documented. Adverse, unplanned and untoward events are responded to in an appropriate and timely manner. Appropriate employment processes are adhered to. An education and training programme for staff is established. Care staff and residents reported that staffing levels are adequate to meet the needs of the 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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Registered nurses are responsible for care plan development with input from residents and relatives. Initial assessments, care plans and evaluations in resident files were completed within the required timeframes. Residents confirmed that the care provided meets their needs. The general practitioner or nurse practitioner reviews the residents three monthly or sooner if required.

Planned activities are appropriate to the resident's assessed needs and abilities.

Medications are managed and administered in line with legislation and current regulations. Staff responsible for medication administration have completed medication competencies and medication education.


Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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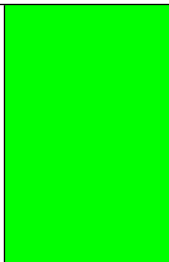
There is a current building warrant of fitness in place. Preventative maintenance is being implemented.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has policies and procedures to ensure that restraint is used as a last resort and is implemented safely when required. Enabler use is voluntary. There were six residents with restraint and one resident occasionally using a T-belt while up in a chair. Two residents requested bed sides as enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (registered nurse) uses the information obtained through surveillance to plan and determine infection control activities, resources, and education needs within the facility. Infection control events are collated monthly and analysed. Information is discussed at quality and staff meetings. There have been no outbreaks. The infection control programme is reviewed six monthly.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	1	3	0	0
Criteria	0	38	0	1	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the facility manager using a complaints' register. The complaints process is linked to the quality management system. There have been no complaints lodged since the previous audit.</p> <p>Residents (three rest home and one hospital) and family members advised that they are aware of the complaint procedure. Discussion around concerns, complaints and compliments were evident in facility meeting minutes.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is a policy to guide staff on the process for open disclosure. Residents/relatives have the opportunity to feedback on service delivery through open-door communication with management. Monthly resident meetings encourage open discussions around the services provided (meeting minutes sighted). Accident/incident forms reviewed and the family communication sheet that is held in each resident file provided evidenced that families are informed of incidents/accidents. Two families interviewed (one rest home, one hospital) stated they are notified promptly of any changes to residents' health status including any incidents or accidents. This previous area identified for improvement is now being met by the service.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised</p>

		resident should they wish to do so. There is access to an interpreter service as required through the DHB.
<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>Whangaroa Health Services is governed by a trust board, comprised of representatives from the local community. An interim general manager oversees operations of the health service, which includes a medical centre and an aged care facility. He was unavailable during the audit.</p> <p>The aged care facility (Kauri Lodge) is certified for up to 25 residents. Ten beds are dedicated rest home level beds and the remaining fifteen beds are suitable for either rest home or hospital levels of care. On the day of the audit, the facility was fully occupied with 25 residents. This included seventeen residents at rest home level, including one resident on respite. There were eight residents at hospital level care including one long-term services chronic health condition (LTS-CHC) funded resident and one resident on a Ministry of Health young person with a disability (YPD) contract. All remaining residents were under the DHB age-related residential care services agreement.</p> <p>A strategic plan for the Whangaroa Health Services Trust was in draft awaiting board ratification. The interim GM provides a monthly service management report to the board. Kauri Lodge has implemented an annual quality assurance and risk management plan that lists operational objectives and is linked to key performance indicators. Monitoring of these KPIs is linked to the internal auditing programme.</p> <p>The clinical manager has completed at least eight hours of professional development activities related to her role and responsibilities.</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 clinical manager and support services manager (interviewed), have implemented a quality system that was purchased from an external consultant (Healthcare Compliance Solutions). System components cover the collection, collation and reporting of data (eg, incidents/accidents, complaints (if any), infection control, restraint use) and the development of corrective actions that have been developed as a result of data analyses. Staff interviewed (two healthcare assistants, two registered nurses (RNs), and a chef,) confirmed they are actively involved in the quality management programme being implemented.</p> <p>Policies and procedures implemented provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. There are clinical policies/procedures to support hospital and rest home level care.</p> <p>An internal audit programme is being implemented as per the audit schedule. Service meetings include; a monthly clinical quality meeting, a monthly staff meeting, and a monthly residents' meeting. Regular agenda items include accidents/incidents, infections, complaints, training, internal audit results, corrective actions, health and safety and restraint minimisation. Meetings are held as scheduled and meeting minutes</p>

		<p>reflect quality results being discussed with staff. This is an improvement from the previous audit.</p> <p>Where internal audits reflect areas for improvement, a corrective action plan is generated and transferred to a corrective action register. Corrective actions that reflect improvements are either signed off when resolved or are signed off when the audit has been repeated and meets the acceptable target. This area previously identified for improvement is now being met.</p> <p>There is a health and safety, and risk management system being implemented. There is a current hazard register that reflects evidence of regular monitoring. Staff confirmed they are kept informed on health and safety matters at meetings.</p> <p>Falls management strategies include assessments after falls and developing individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training addressing this.</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>The service collects incident and accident data and enters them into an electronic register for analysis. The system provides monthly reports, which are then discussed at the monthly CQI and staff meetings.</p> <p>There were 10 resident-related incident forms reviewed that were documented electronically. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations were completed for unwitnessed falls. The healthcare assistants interviewed could discuss the incident reporting process. The clinical manager investigates and signs off on all incident reports.</p> <p>The clinical manager interviewed could describe situations that would require reporting to relevant authorities. There has been one Section 31 notification since the previous audit for a pressure injury.</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>	PA Moderate	<p>There are human resources management policies in place. Five staff files were reviewed (one clinical manager, two registered nurses and two healthcare assistants) to evidence that reference checks were completed before employment was evidenced. Signed employment agreements and job descriptions were sighted. Copies of practising certificates for RNs were sighted.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed could describe the orientation process and stated that they believed new staff were adequately orientated to the service. Staff appraisals were behind schedule in four of the five staff files of staff who had been employed for over one year.</p> <p>Review of the in-service education programme for 2018 and 2019 reflected less than eight hours of training per person. Competency paperwork that is completed is not being checked by an assessor. This previous</p>

		<p>area identified for improvement remains.</p> <p>Four of six registered nurses have completed interRAI training.</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>	FA	<p>A roster in place which provides sufficient staff cover for the provision of care and service to 25 residents. There is a recognised first aid staff member/RN on each shift. This is an improvement from the previous audit.</p> <p>The clinical manager (RN) is rostered Monday to Friday and on call. A registered nurse is rostered each shift. Additional RN staffing is rostered to complete interRAI assessments (as needed).</p> <p>Rose Wing (10 rest home level residents) is staffed with one healthcare assistant on each shift.</p> <p>Tui Wing (seven rest home and eight hospital level residents) is staffed with two long shift healthcare assistants on the AM shift, and one long and one short healthcare assistant on the PM shift.</p> <p>Night shift: There is one healthcare assistant to support the rostered RN.</p> <p>Activities staff are rostered four days a week. Staff are employed specifically for housekeeping, laundry and kitchen duties.</p> <p>The clinical manager interviewed advised that additional staff can be rostered to meet additional needs of the residents.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</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>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medication reconciliation is completed by the RN on delivery of medication and any errors are fed back to pharmacy. All medications were securely and appropriately stored on day of audit.</p> <p>All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. RNs have completed syringe driver training.</p> <p>The service uses an electronic medication management system. Ten medication charts were reviewed, all charts have photo identification, allergies documented, and evidence of a three-month review by either the GP or the NP. All 'as required' medications indications for use were documented. Staff were observed to be safely administering medications. Registered nurses and HCAs interviewed could describe their role in regard to medicine administration. Standing orders are not used. There were no self-medicating residents</p>

		<p>at the time of audit.</p> <p>The medication fridge temperatures are recorded weekly and these are within acceptable ranges.</p> <p>There is a signed agreement with the pharmacy.</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>All meals and baking are prepared and cooked on site in the centrally located kitchen. All staff working in the kitchen have food safety certificates (NZQA). Kauri Lodge have applied for a food control plan. Food control documentation is in place and maintained appropriately.</p> <p>Meals are pre-plated for hospital level residents and residents with special (puree) diets in the Tui wing. Kauri Lodge has recently implemented the use of food moulds to make the puree meals appear more appetising. Meals are transported in a bain marie to the rest home in the Rose wing and plated by the chef.</p> <p>Special diets are being catered for. The menu is designed and reviewed by a registered dietitian. Residents have had a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. The chef was aware of changes in resident's nutritional needs and talks to the residents at least daily and seeks feedback on the menu.</p> <p>Fridge, freezer temperatures and food temperatures were undertaken and documented and are all within range. Residents and relatives interviewed reported satisfaction with food choices. Special equipment was available. There are nutritional snacks available in the kitchen for residents when the kitchen is closed.</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>	PA Moderate	<p>When a resident's condition alters, the RN initiates a review and if required a GP visit. Communication to the GP for a residents' change in health status were sighted in the resident's files. Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met.</p> <p>Care plans sampled were resident goal focused, however, not all interventions were reflective of current needs of the residents. The care staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently where necessary.</p> <p>Wound assessments, plans and evaluations are paper based and were in place for all current wounds (three superficial skin tears). There were three residents with pressure injuries. One stage 3 facility acquired, and two stage 2 non facility acquired pressure injuries, all of which are now resolving. All pressure injuries had a current wound assessment and plan, however not all evaluations were reflective of the wound. GPs are notified of all wounds. Adequate dressing supplies were sighted in the treatment rooms. The NP visits weekly and the district nurses oversee the dressings for the resident with the stage 3</p>

		<p>pressure injury. Staff receive regular education on wound management.</p> <p>Continence products are available and resident files include urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>The monitoring charts were in a separate file and are checked at the end of each shift by the registered nurse. On the day of the audit there were monitoring forms in place for blood sugar monitoring, which was fully completed. A behaviour monitoring chart was in place and completed in line with documentation in the progress notes and incident reports. Pain assessments had been completed. There were no residents experiencing ongoing pain on the day of the audit. The previous finding has been partially addressed.</p> <p>Neuro observations were sighted following unwitnessed falls in resident files.</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 one diversional therapist who works 32 hours a week over four days and is currently completing Careerforce training to become a diversional therapist. The diversional therapist was not available on the day of the audit. There is one regular volunteer who assists with activities and colouring activities. When the diversional therapist is not available the social worker helps out with activities alongside the volunteer. Healthcare assistants were observed talking with residents and some residents were watching the television in both lounge areas on the day of the audit. Residents were observed participating in some physiotherapy exercises.</p> <p>There is a large whiteboard in the hallway and the monthly programme is documented on this. Residents have the choice of a variety of activities in which to participate. These include (but are not limited to) exercises, crafts, movie afternoons, singing, games and quizzes. A singing group visits the facility weekly and have morning tea with the residents during their visit. There is a monthly high tea with all the trimmings. The diversional therapist supports residents to do their shopping and manage the pets. There are one-on-one activities available for residents who prefer not to attend the group activities. Church services are held at least monthly, and the nuns visit weekly to give communion.</p> <p>Resident meetings are held monthly, suggestions are sought for outings and activities to plan for the following month.</p> <p>Residents and relatives interviewed were happy with the variety of activities on offer, residents commented on making suggestions for the planner at resident meetings.</p> <p>All resident files reviewed including the resident on respite, had an activity plan or activity assessment documented. Activity plans are evaluated at least six-monthly. The previous finding has been addressed.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>All initial care plans were evaluated by the RN within three weeks of admission. Long term care plans were updated six monthly. Evaluations are discussed at the multi-disciplinary meetings which the GP or NP attend with the residents and relatives, progression towards goals are discussed and documented. Relatives are updated if unable to attend.</p> <p>Short-term care plans were evidenced in the sampled files however, not always reviewed or evaluated in a timely manner. Short term care plans sighted were used for infections. There is at least a three-monthly review by the medical practitioner. The relatives interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</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>Whangaroa health have a current building warrant of fitness, which expires on 31 May 2020. Hot water temperatures are checked monthly and were within expected ranges. The previous finding has been addressed.</p> <p>Medical equipment and electrical appliances have been tested and tagged and calibrated. There is a planned schedule to maintain regular and reactive maintenance and the maintenance officer interviewed could demonstrate progress. Residents were observed to mobilise safely within the facility. There was safe access to the outdoor areas for people using mobility aids. Seating and shade is provided.</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>	<p>FA</p>	<p>Whangaroa Health has implemented an infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. A registered nurse is the designated infection control coordinator with support from all staff members of the infection control team. Infection control is discussed at staff meetings. Minutes are available for staff. Spot infection control audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed on a six-monthly basis. The previous finding has been addressed.</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>	<p>FA</p>	<p>Whangaroa Health continue to implement their infection surveillance programme. Individual infection report forms were completed for all infections on the electronic system. Infections were included on a monthly register and graphed on the online system; a monthly report was completed by the infection control coordinator. Whangaroa Health aimed to reduce the rate of UTIs, by increasing hydration and providing education around good hygiene practices, the rate of UTIs have decreased and remained below benchmark. The graph is displayed on the noticeboard in the corridor as a reminder to encourage fluid</p>

control programme.		<p>intake for residents.</p> <p>Infection control (IC) issues were discussed at the various facility meetings. The IC programme is linked with the quality programme and benchmarked by a national benchmarking service. The infection control programme has been reviewed six monthly.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint minimisation and safe practice policies and procedures are documented for the service. There is a designated restraint coordinator who was unavailable during the audit. The clinical manager was interviewed in their absence.</p> <p>A restraint/enabler register is being implemented. There were six residents with restraint and one resident occasionally using a T-belt while up in a chair. Two residents requested bed sides as enablers. Appropriate assessments and consents were documented for the two enablers.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>The staff attendance at in-service training averaged five individuals attending. Education training modules using an online system failed to indicate that the competencies completed were assessed.</p> <p>Performance appraisals are behind schedule for staff.</p>	<p>The auditor was unable to evidence that care staff have attended a minimum of eight hours of training over the past 12 months. Six in-services have been provided over the past one year with an average of five staff attending. For those staff who have completed online training, their competency paperwork submitted has not been assessed.</p> <p>Performance appraisals are behind schedule by 18 months or longer in four of the five staff files reviewed.</p>	<p>(i). Ensure that staff attend a minimum of eight hours of training per year.</p> <p>(ii) Processes are required to ensure that competencies submitted are assessed.</p> <p>(iii) Ensure that annual</p>

				performance appraisals are completed for staff. 60 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>All residents have interRAI assessments completed within timeframes on admission, however the interRAI assessments are not always completed within the six-month timeframes. This is a continued shortfall from the previous audit. Risk assessments are completed on admission, but are not always reviewed when a change on resident condition occurs.</p>	<p>i) One rest home and two hospital level residents interRAI assessments were not completed on a six-monthly basis since the previous audit.</p> <p>ii) Two hospital and one rest home residents risk assessments were not updated to reflect changes in health status.</p>	<p>i) Ensure all interRAI assessments are completed on a six-monthly basis.</p> <p>ii) Ensure all risk assessments are updated in a timely manner.</p> 60 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 Moderate</p>	<p>Care planning is overall well documented and completed in partnership with residents and relatives as appropriate. The goals are set by each resident; however, two of five resident files did not have current ongoing interventions documented in the long-term care plan. All pressure injuries had a current wound assessment and plan, however not all evaluations were reflective of the wound. This continues to be an area requiring improvement.</p>	<p>i) The wound chart (assessment, plan and evaluation) for the stage three pressure injury is not indicative of which wound it is referring to.</p> <p>ii) There were no instructions for HCAs on care of skin care/ dressings in either the long or short-term care plans.</p> <p>iii) Not all interventions were individualised to reflect "usual" behaviours of a hospital level resident</p>	<p>i) Ensure all aspects of the wound chart is completed especially indicating where the wound is located.</p> <p>ii) Ensure all short-term</p>

			who has challenging behaviours.	care plans for wounds include instructions around care of dressings. iii) Ensure all interventions are individualised to each resident. 90 days
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	PA Low	The long-term care plans in the long-term resident files (one respite) were reviewed and updated routinely at six-month intervals, however, not consistently updated when there has been a change in condition. Short-term care plans were overall reviewed regularly and resolved.	The short-term care plan for the stage three pressure injury had not been reviewed or transferred to the long-term care plan in a timely manner.	<p>Ensure short-term care plans are reviewed on a regular basis and transferred to long-term care plan in a timely manner.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.