Presbyterian Support Services Otago Incorporated - Ross Home & Hospital

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:	Presbyterian Support Otago Incorporated
Premises audited:	Ross Home and Hospital
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 22 March 2016 End date: 23 March 2016

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: 119

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
	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

Ross Home is certified to provide care to up to 124 at rest home level care, and hospital level care including geriatric, medical and psychogeriatric. There were 119 residents on the days of audit. Residents, relatives and the GP interviewed spoke positively about the service provided.

Ross Home is managed by a registered nurse who reports to the director of Enliven residential aged care services and is also supported by unit nurse managers, an operations support manager, a quality advisor and a clinical nurse advisor.

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

The service has maintained continuous improvement in the area of organisational management. The organisation has rebranded their service philosophy to incorporate the Enliven model of care delivery.

The service has addressed the two previous certification audit findings around education/training and activities plans for psychogeriatric residents.

This audit identified areas for improvement around complaints management, adverse events, timeframes for assessments, wound care documentation, evaluations, medication management and enabler review.

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.		Some standards applicable to this service partially attained and of low risk.

Communication with residents and families is maintained and this was confirmed on interviews. A system of complaints is available to service users.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

The director and management group of Enliven residential aged care services provide governance and support to the manager. The quality and risk management programme includes the Enliven service philosophy, goals and a quality planner. Quality activities are conducted, which generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Resident meetings are held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. A comprehensive education and training programme has been implemented. Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Lifestyle support plans are developed by the service's registered nurses, who also have the responsibility for maintaining and reviewing the support plans. Risk assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. Lifestyle support plans are evaluated six monthly or more frequently when clinically indicated. There is documented evidence of allied health involvement into the residents care.

The activity programme is varied and reflects the interests of the residents including community interactions across the three levels of care. There are 24-hour activity/recreational plans in place for psychogeriatric residents.

There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Competencies are completed. Medication profiles are reviewed by the general practitioner three monthly or earlier if necessary.

The menu is designed and reviewed by a registered dietitian. Residents' individual needs are identified. There is a process in place to ensure changes to residents' dietary needs are communicated to the kitchen. Nutritious snacks are available at all times in the psychogeriatric unit.

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.

The service displays a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.

A restraint policy includes comprehensive restraint procedures. The documented definition of restraint and enablers aligns with the definition in the standards. There are currently six residents with restraint and four with enablers. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

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 control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	1	9	0	6	1	0	0
Criteria	1	30	0	8	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	The service has a complaints policy that describes the management of the complaints process. There is a complaints form available. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a complaints register. Complaints for 2015 and 2016 were reviewed. Not all complaints evidenced completed documentation. Complaints have been investigated with corrective actions identified. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an	FA	Eight residents (five rest home and three hospital) and two relatives (one rest home and one psychogeriatric) interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incidents/accidents forms reviewed include a section to record family notification. All forms sampled indicated family were informed or if family did not wish to be informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status.

environment conducive to effective communication.		
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	CI	Ross Home is one of seven aged care facilities under the Enliven residential aged care services division of Presbyterian Support Otago (PSO). The nurse manager has been in the role for 16 years and is supported by four unit nurse managers (one was absent on the days of audit). The home is certified to provide rest home and hospital level care (including medical, geriatric and psychogeriatric) for up to 124 residents with 119 residents on the days of audit. There are no dual purpose beds and no respite residents. On the days of audit, there were 39 rest home residents, 58 hospital residents and 22 psychogeriatric residents. One psychogeriatric resident was under the age of 65 and one hospital resident was on a palliative care contract. All residents were on the age related contract. The organisation has a current strategic plan, a business plan 2015 - 2016 and a current quality plan for 2015 - 2016. There are clearly defined and measurable goals developed for the strategic plan and quality plan. The strategic plan, business plan and quality plan all include the philosophy of support for PSO. The organisational quality programme is managed by the nurse manager, quality advisor and the director of Enliven residential aged care services. The service has an annual planner/schedule that includes audits, meetings and education. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. The nurse manager has maintained at least eight hours annually of professional development activities related to managing the facility.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	There is a board approved PSO strategic plan, which incorporates residential and non-residential services for the older persons, as well as community, family and youth support programmes provided by PSO. The business plan for 2015-2016 outlines the financial position for PSO with specific goals for the coming year. There is a quality plan in place for 2015-2016. Quality improvement initiatives for Ross Home are developed as a result of feedback from residents and staff, audits, benchmarking and incidents and accidents. Ross Home is part of the PSO internal benchmarking programme and an external benchmarking company, QPS. Feedback is provided to the quality advisor and clinical nurse advisor. A report, summary and areas for improvement are received and actioned. Progress with the quality assurance and risk management programme is monitored through the various facility meetings. Monthly and annual reviews are completed for all areas of service. Minutes are maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with registered nurses and care workers confirm their involvement in the quality programme. Resident/relative meetings occurs three monthly. An internal audit schedule is being

		implemented. Areas of non-compliance identified at audits are actioned for improvement. The service has a health and safety management system. Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility. There are designated health and safety staff representatives. The service collects information on resident incidents and accidents as well as staff incidents/accidents. A resident survey and a family survey are conducted biennially. The surveys evidence that residents and families are over all very satisfied with the service. The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the resident care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. Falls prevention strategies include: falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, eye checks, correct seating, increased supervision and monitoring and sensor mats if required.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Low	Incident and accident data is collected and analysed and benchmarked through the PSO internal benchmarking programme. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for January and February 2016 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care was provided following an incident with the exception of neurological observations. Documentation including care plan interventions for prevention of incidents was fully documented. Incident reports were completed and family notified as appropriate. There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The nurse manager is aware of the responsibilities in regards to essential notifications. An example was provided of a recent section 31 notification.
Standard 1.2.7: Human Resource Management Human resource	FA	The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files were reviewed including the three unit nurse managers, three registered nurses and three care

management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		workers. All files included all appropriate documentation. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed that new staff were adequately orientated to the service. Care workers are orientated by 'preceptors'. Annual appraisals are conducted for all staff. The previous certification audit identified issues around education and training, restraint competencies and attendance records. The in-service calendar for 2015 has been completed and a plan for 2016 is underway. Education records reviewed for 2015 evidenced that training has been provided by way of education sessions, toolbox talks and mini-education sessions conducted at handover. Competencies are completed around restraint, syringe driver, sub-cut fluids, catheterisation and standing orders. Medication competencies for unit nurse managers were not current (link 1.3.12.3). Attendance records were reviewed and evidenced that attendance numbers have improved. Staff have attended education and training sessions appropriate to their role. The service has addressed this previous finding. Care workers either have completed the national certificate in care of the elderly or have completed or commenced the Careerforce aged care education programme. There are 16 care workers who work in the psychogeriatric unit. Fifteen have completed the required dementia unit standards and one is in the process of completing. This staff member has been employed in the past six months. The nurse manager, clinical unit managers, registered nurses and care workers are able to attend external training including conferences, seminars and sessions provided by PSO and the local DHB. A number of staff including care workers have completed walking in another's shoes and a palliative care course.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	PSO Ross Home has a four weekly roster in place that ensures that there is sufficient staff rostered on in each unit. Each rest home unit has a minimum of one care worker on duty with support from a registered nurse from the hospital units. Each hospital unit has at least one registered nurse and one care worker on duty. The psychogeriatric unit has a minimum of one registered nurse and one care worker on duty. The full-time facility manager is a registered nurse. Core care staffing was reported as stable with some staff having worked at Ross Home for over 15 years. Interviews with staff, residents and family identify that staffing is adequate to meet the needs of residents.
Standard 1.3.12: Medicine Management	PA Moderate	There are medication management policies and procedures in place that follows recognised standards and guidelines for safe medicine management practice in accordance with the guideline: medicines care guides for aged residential care. Registered nurses, enrolled nurses and care workers administer medications and have attended annual medication education provided by a pharmaceutical representative. Enrolled nurses and care workers have

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		completed an annual medication competency. Not all RNs have completed the annual medication competency. Regular medications are checked on delivery against the medication chart by the RN on duty. 'As required' medications are supplied in bottles/packets. Some 'as required' medications in stock were outside the expiry dates and two were not currently charted on the medication chart. Standing orders are not used; however, one medication with no corresponding resident name, was evident. Eyes drops were not all dated on opening. All medications were stored securely in each wing. Medication fridges are used to store medications requiring refrigeration. Medication fridges are monitored daily, however there is no documented evidence of corrective action for fridge recordings outside of the acceptable range. Medication administration was observed and the procedure followed by the registered nurse was correct and safe. The service uses an electronic medication system. The self-medicating policy includes procedures on the safe administration of medicines. There were three residents self-medicating who had been competency assessed by the enrolled nurse but not countersigned by the RN. The resident's self-medicating competency is reviewed three monthly and self-administration entered into the electronic medication system. Sixteen medication charts (six rest home, six hospital and four psychogeriatric) were reviewed on the electronic medication system. All charts had photo identification and allergy status identified. Medication charts had been reviewed at least three monthly by the GP.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals are prepared and cooked on-site. The qualified chef is supported by a weekend cook and morning and afternoon kitchen hands. The four weekly winter and summer menus are reviewed six monthly by the company dietitian. Meals are plated and delivered insulated with plate bottoms and covers. Special dietary needs, preferences and dislikes are accommodated. A full dietary assessment is completed for all residents at the time they are admitted and an internal memo alerts the chef to any dietary changes and any residents with weight loss. Special equipment is available such as lipped plates/assist cups/grip and built up spoons as required. Residents stated their preferences and dislikes were accommodated. There is a large, well-equipped kitchen. Fridge, freezer and meal temperatures are recorded and action taken as needed. Cleaning schedules are maintained. All foods were dated and stored correctly. Internal audits are undertaken. Food satisfaction surveys are conducted. Resident meetings discuss food as part of their meetings. Food services staff have completed food safety training. The chef has completed an assessor qualification. Staff have completed chemical safety training.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The lifestyle support plan has been recently reviewed to reflect the interRAI assessment process and this new format had been introduced in three of the eight files reviewed. The outcomes of risk assessment tools had been reflected in the lifestyle plans in all files reviewed. The lifestyle plans described the supports and intervention required to meet the resident's needs. Activity and recreational preferences are included in the lifestyle plan. This includes a 24-hour activity, motivational and recreation therapy plan for psychogeriatric residents. The previous finding around 24-hour activity plans for psychogeriatric residents has been addressed.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	When a resident's condition changes, the RN initiates a GP or nurse specialist consultation. There is documented evidence of family notification for a resident change in health status. The care being provided is consistent with the needs of residents as demonstrated on the overview of the care plans, discussion with family, residents, staff and management. Dressing supplies are available and a treatment room is stocked for use. Skin and wound assessment/evaluation tools are in place for all wounds however, there is no evidence of a full wound assessment completed for all wounds including the one pressure injury. There was no short-term care plan in place for the management of the pressure injury. Photographs and wound evaluations provide a record of the healing progress. Wound management in-service has been provided as part of annual training. Registered nurses interviewed were able to describe access to specialist services if required. Continence products are available and resident files include a 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.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	Ross Home employs four activity staff (three diversional therapist – DT and one activity coordinator) for a total of 108 hours per week. The activity team attend regional DT workshops and relevant on-site education. All of the activity team have a current first aid certificate. All of the activity team rotate to each wing. Two students (physiotherapy and occupational therapy) are employed to provide activities in the psychogeriatric unit form 6-8pm Monday to Sunday. There is a separate activity programme for each wing (two hospital, two rest home and one psychogeriatric) that meets the individual physical, cognitive, intellectual and spiritual/cultural preferences of the residents. Small group activities and one on one time with residents is included in the programmes. The service is currently implementing the Enliven philosophy and the activity team were able to describe how this is integrated into the activity programme. Special events and themes are celebrated involving all staff and families. Links with the community are maintained such as going shopping, library and attending community groups and activities. Regular van outings

		are provided for residents of all levels. A recent quality initiative is the introduction of individual picture books of participation in activities and outings for families to view when they visit. A resident personal and lifestyle profile is completed on admission and each resident has an individual activity plan that is reviewed six monthly at the same time as the long- term lifestyle support plan. Residents in the psychogeriatric unit have individual activity plans over a 24-hour period.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Lifestyle support plans are reviewed and resident care is evaluated six monthly and this was evidenced on all resident files reviewed. Six monthly reassessments are paper based with the service moving towards interRAI as six monthly reassessments become due from 1 January 2016. Written evaluations are completed in consultation with the multidisciplinary team including the GP and any other allied health professionals involved in the care of the resident. Not all resident changes to care have been reflected in the care plan as identified during the evaluation process.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service displays a current building warrant of fitness that expires on 4 December 2016.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections. Antibiotic use is collated six monthly and the outcome linked to RN training. Individual short-term care plans are available for each type of infection. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly, three monthly and annually. Outcomes and actions are discussed at the staff and management meetings. A three monthly infection report is provided to the PSO clinical governance group. Infection rates are benchmarked externally. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager and to organisational management. There have been no outbreaks reported since the last audit.

control programme.		
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	PA Low	The service has restraint minimisation and safe practice policy in place. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures. Enablers are voluntary. There are six residents with restraint and four with enablers at Ross Home. Not all enabler files reviewed evidenced three monthly reviews and consents were not all signed appropriately. Staff are trained in restraint minimisation, challenging behaviour and de-escalation and competencies are completed.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Low	Three complaints for 2015 and one complaint received for 2016 were reviewed. Each complainant had been provided with a complaint acknowledgement letter. There is evidence of investigations conducted, staff meetings and corrective actions implemented. Advised by the manager that a verbal response to complaint outcomes is provided to complainants. Feedback is provided to staff via unit meetings and individual staff performance management.	The complaints folder reviewed did not evidence that letters of response to the complainants included investigations and outcomes of complaints.	Provide evidence that complainants receive a written response to complaints and that this includes the investigations and outcomes achieved. 60 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or	PA Low	Incidents and accidents are reported with documentation completed by care workers and registered nurses. The unit nurse managers review all forms relating to their residents and document further investigations. The facility manager advised that the unit managers then send through the monthly stats for	Neurological observations were commenced for five residents who sustained an unwitnessed fall however, only one set of observations were recorded.	Ensure that a full set of recorded observations are completed where neurological observations are

untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.		collation. There is evidence that appropriate assessment of the resident has been conducted following adverse events with the exception of completed neurological observations. A sample of 32 incident reports were reviewed for January and February 2016 for all five units. Advised by the unit nurse managers that neurological observations are conducted for residents who have sustained an unwitnessed fall.		required. 60 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	Medication charts reviewed corresponded with the signing administration records for regular and as required medications. Three as required medications evidenced to be past expiry dates and two were no longer prescribed. Standing orders are no longer in use but an unnamed medication was found in the medication fridge. Eye drops were dated in the medication trolleys in the hospital and psychogeriatric wings. Medication fridges were monitored daily however, not all fridges had temperatures that were within the acceptable range.	(i)Three as required medications in use were found to have expired (rest home and hospital) and two expired as required medications (rest home) were no longer prescribed on the medication chart; (ii) one un-named glucagon injection (previously a standing order) was found in the hospital medication fridge; (iii) eye drops in two rest home medication trolleys were not dated on opening; and (iv) two medication fridges (one rest home and one hospital) were consistently reading outside of the acceptable temperature range.	(i)Ensure all as required medications are prescribed and within the expiry dates; (ii) Ensure all medications in stock are prescribed for use; (iii) Ensure all eye drops are dated on opening; and (iv) Ensure all medication fridges are maintained within the acceptable temperature range. 30 days
Criterion 1.3.12.3 Service providers responsible for medicine	PA Low	Care workers and enrolled nurses who administer medications in the rest home have completed annual medication competencies. Registered nurses administer medications in the hospital and psychogeriatric wings. Registered nurses have	There are four RN/unit managers employed who have not completed an annual medication competency.	Ensure all RNs including unit nurse managers complete annual medication

management are competent to perform the function for each stage they manage.		completed annual medication competencies with exception of the unit nurse managers.		competencies 60 days
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	There were three rest home residents self-medicating on the day of audit. Self-medication competencies had been completed by the enrolled nurse. There was no RN involvement in the assessment process.	The RN had not countersigned the three self-medication competencies.	Ensure the RN countersigns the self-medication assessments completed by the enrolled nurse. 60 days
Criterion 1.3.3.3 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.	PA Low	Resident files reviewed evidenced initial assessments and risk assessments were completed on admission. Long-term lifestyle support plans had been developed within three weeks and reviewed six monthly or earlier for health changes. InterRAI assessments had not been completed within the prescribed timeframes for admissions and a change in health status	(i) Two residents (one rest home and one hospital) did not have an interRAI assessment completed within 21 days of admission, and (ii) there was no interRAI assessment completed for one resident with a change of level of care to hospital level.	(i) Ensure interRAI assessments are completed within 21 days of admission, and (ii) ensure interRAI assessments are completed for residents with a change to health status/level of care. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to,	PA Low	On the day of audit, there were 10 minor wounds, two leg ulcers, two surgical wounds and one stage III hospital acquired pressure injury. All wounds were evaluated at the required frequency however, not all wounds had a full initial assessment completed. Short-term care plans were in place for all wounds	(i) Wound assessments were not in place for three surgical wounds, one cyst, one sinus and one pressure injury, (ii) there was no short-term care plan in place for the management of the pressure injury.	(i) Ensure wound assessments are completed for all wounds. (ii) Ensure there are short-term care plans in place

meeting the consumers' assessed needs, and desired outcomes.		except the pressure injury.		for all wounds. 90 days
Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Low	Six monthly multidisciplinary meetings are held with the GP, resident/relative and any other allied health professional involved in the residents care. A written evaluation is completed against the resident goals and identify if the goals are met or unmet. Long-term lifestyle support plans of two residents have not been updated to reflect the resident's needs.	Lifestyle support plans have not been updated to reflect the resident's current status for (i) one rest home resident with continence concerns, and (ii) one hospital resident with high risk of pressure injury.	Ensure residents' lifestyle support plans reflect the residents' current health status. 90 days
Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.	PA Low	Restraint and enabler documentation was reviewed for one hospital resident with restraint (bedrails), one psychogeriatric resident with restraint (fall out chair with attached tray table) and two hospital residents with enablers (bedrails). Documentation was completed for one of two enabler files reviewed.	(i) Three monthly reviews had not been conducted for one resident with an enabler; and (ii) one enabler consent has been signed by a family member.	(i) Ensure that three monthly reviews of enablers are completed and documented; and (ii) ensure that consents for enablers are completed appropriately. 60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	CI	The director and management group of Enliven provide governance and support to the nurse manager. The director reports to the PSO board on a monthly basis. Organisational staff positions also include a full-time operations support manager, a clinical nurse advisor and a quality advisor. The director chairs six weekly management meetings for all residential managers where reporting, peer support, education and training takes place. The nurse manager of Ross Home provides a monthly report to the director of Enliven services on clinical, health and safety, service, staffing, occupancy, environment and financial matters.	Ross Home has embraced the rebranded PSO philosophy of Enliven (previously known as Valuing Lives) and this was evident in service delivery and feedback. The PSO Enliven philosophy includes six guiding principles for service delivery and includes activity, security, respect, choice, relationships and contribution. The Enliven model of support is holistic and focuses on supporting older people to live valued and meaningful lives. Following review of policies, procedures, discussion with staff and management, residents and relatives it is apparent that the service has exceeded the required standard around implementation of the organisation’s vision and values. The Enliven action plan has been communicated to all new and existing staff. The Enliven programme has been communicated to staff at orientation and as part of the education programme. All staff have been provided with the Enliven service philosophy guidebook, which describes how each guiding principle is implemented.

		PSO has recently rebranded their services under the Enliven philosophy. The previous Valuing Lives philosophy has been reviewed with new guiding principles developed under the banner of Enliven. The underlying framework based on social role valorisation remains unchanged. All areas of service at Ross Home are discussed at six weekly PSO management meetings where the manager reports to the director, participates in peer review and is part of the wider organisations review and implementation of policies and procedures. A clinical governance advisory group (CGAG) reports to the PSO board three monthly on a range of performance issues and is responsible for quality of care, continuous quality improvement, minimising risk and fostering an environment of excellence in all aspects of service provision. The clinical advisory group reviews all clinical indicators benchmarked by QPS. The organisation has developed 16 continuous quality improvement (CQI) groups with responsibilities for chairing and facilitating of the groups; delegated to various senior staff members within the organisation. Each group is responsible for review of programmes, implementing and disseminating information. The nurse manager at Ross Home is on the moving and handling group, workforce development and food service. The unit nurse managers are also involved in the CQI groups including restraint, dementia, documentation, falls prevention, medicines, pressure injury prevention, benchmarking and infection control.	The Enliven philosophy has been incorporated into all aspects of service e.g. regular agenda item at quality meetings and is embedded in all staff training. Care staff interviewed were knowledgeable regarding the six guiding principles. All residents have been provided with information on the Enliven philosophy and the PSO website further explains the philosophy of care for prospective residents and families. Implementation of the Enliven philosophy is included in staff orientation, annual staff training, discussion at resident meetings, individual and personalised care planning and resident and family satisfaction surveys. It is a major focus in the way staff provides care. Staff have been involved in this quality project (which includes specific training) and a focus to making a difference to the lives of people using their services is apparent. The recent resident satisfaction survey identified that 100% were overall very satisfied and respondents agreed that the care at Ross Home had made a 100% positive difference in their lives. Residents interviewed confirmed that they were well cared for and were give choices in their everyday lives. They also stated that staff were very caring and respectful and that they felt safe and their needs were met.

End of the report.