

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: 8 October 2019 End date: 9 October 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:	122



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

Ross Home is one of eight aged care facilities under the Enliven residential aged care services division of Presbyterian Support Otago (PSO). The manager has been in the role for 19 years and is supported by four-unit managers and PSO head office staff. The home is certified to provide rest home and hospital level care (including medical, geriatric and psychogeriatric) for up to 124 residents with 122 residents on the days of audit.

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

The service has maintained continual improvement ratings relating to communication systems.

One improvement which was identified at certification audit around completion of interRAI assessments remains an area for improvement.

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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Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including when a resident is involved in an incident or has a change in their current health. There is an established system implemented for the management of complaints. There are very few complaints received.

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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Services are planned, coordinated, and are appropriate to the needs of the residents. A manager/registered nurse (RN) is responsible for day-to-day operations. She is supported by four-unit managers/RNs. Goals are documented for the service with evidence of regular reviews.

A quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training for staff includes in-service education, impromptu talks and competency assessments.

Registered nursing cover is provided seven days a week and on call 24/7. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

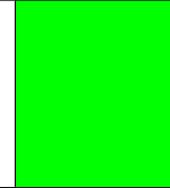
Continuum of service delivery

<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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The facility has introduced an electronic resident management system and all residents have their lifestyle support plans recorded on this programme. Lifestyle support plans are holistic and goal oriented. The programme includes risk assessment tools and monitoring forms which are completed along with interRAI assessments. Lifestyle support plans are evaluated six monthly or more frequently when clinically indicated. The activities programmes for rest home, hospital and psychogeriatric residents are planned in line with resident's assessed needs and abilities. Community connections are maintained. Medications are managed appropriately in line with accepted guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The four-weekly seasonal menu is reviewed by a registered dietitian who is employed by the service. All food is cooked on site and residents' individual likes and dislikes are catered for.

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.

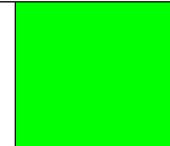


Standards applicable to this service fully attained.

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule 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.

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were eight residents with restraint and no residents with enablers at the time of the audit. Staff receive regular education and training on restraint minimisation and managing challenging behaviours.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Infection surveillance data is gathered and analysed. The benchmarking programme and key performance indicators record infection data. Results of surveillance data are acted upon with relevant and timely reporting.

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	15	0	0	1	0	0
Criteria	1	39	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy describes the management of the complaints process. Complaints forms are available and located in a visible location. Information about complaints is provided on admission. Interviews with four residents (two hospital and two rest home) and family confirmed their understanding of the complaints process. Care staff interviewed (five caregivers (one psychogeriatric, two rest home, two hospital); nine nurses (four unit managers/registered nurses (RNs), four staff RNs, one enrolled nurse (EN)); and four activities staff (three diversional therapists, one activities coordinator) confirmed their understanding of the process around reporting complaints.</p> <p>There is a complaint's register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system. No complaints have been lodged in 2019 (year to date). One complaint lodged in May 2018 was reviewed. Timeframes for responding to the complaint and determined by HDC were met. Corrective actions were implemented, and the complaint was documented as resolved.</p> <p>Complainants are provided with information on how to access advocacy services through the HDC Advocacy Service if resolution is not to their satisfaction.</p>
Standard 1.1.9:	FA	Policies and procedures relating to accident/incidents, complaints and open disclosure alert staff to their

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>responsibility to notify family/next of kin of any accident/incident that occurs.</p> <p>The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. An information booklet is included in the enquiry pack providing practical information for residents and their families. Specific information on the psychogeriatric unit is included in the enquiry pack. Staff are required to indicate if the resident's enduring power of attorney (EPOA) or next of kin have been informed of an accident/incident. Ten accident/incident forms reviewed identified family are kept informed unless justifiable circumstances indicate otherwise. Five relatives interviewed (two rest home, two hospital, one psychogeriatric) stated that they are kept informed when their family member's health status changes or if there has been an adverse event.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.</p> <p>The service has exceeded the criterion around communication with families through the use of video telecommunications.</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>	FA	<p>Ross Home is one of eight aged care facilities under the Enliven residential aged care services division of Presbyterian Support Otago (PSO). The manager is an RN who has been in the role for 19 years and is supported by four-unit nurse managers/RNs.</p> <p>The home is certified to provide rest home and hospital level care (including medical, geriatric and psychogeriatric) for up to 124 residents with 122 residents on the days of audit. There are no dual-purpose beds. There are 38 rest home residents, 60 hospital residents and 24 psychogeriatric residents. One hospital resident was under the long-term support - chronic health conditions contract. Two residents (one psychogeriatric and one hospital) were under a young person with a disability (YPD) contract and two residents (rest home) were on respite. All other residents are under the ARC contract.</p> <p>The organisation has a current annual business plan and quality plan. There are clearly defined, and measurable goals developed and regularly reviewed. The manager has maintained at least eight hours annually of professional development activities related to managing the facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	FA	<p>A quality plan provides oversight to the quality programme. The quality programme is managed by the manager with additional support provided by the Presbyterian Support quality advisor who was interviewed during this audit. The service has an annual planner/schedule that includes audits, meetings and education.</p> <p>Policies/procedures 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.</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>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 a Presbyterian Support internal benchmarking programme. Progress is monitored through the various facility meetings. Adverse events occurring each month (eg, falls, bruising, skin tears, infections) range both above and below the organisation's targets. Minutes for meetings include actions to achieve compliance where relevant. Staff are expected to read the minutes and sign off when read. Discussions with the manager, care staff, the quality advisor and the administrator confirmed their involvement in the quality programme. Resident/relative meetings are held a minimum of twice per year per wing. Six monthly support meetings for family with residents living in the psychogeriatric unit have occurred. An internal audit schedule is being implemented. Areas of non-compliance identified at audits are actioned for improvement.</p> <p>The service has a health and safety management system. Risk management plans are in place 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 hazard register is reviewed regularly and updated as indicated. All new employees and external contractors are required to undertake health and safety orientation.</p> <p>A resident survey and a family survey are conducted annually. The surveys completed for 2019 evidenced that residents and families are overall very satisfied with the service. Corrective actions are implemented where identified.</p> <p>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.</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</p>	<p>FA</p>	<p>Individual reports are completed electronically for each incident/accident with immediate action noted and any follow up action(s) required. Ten accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurological observations are conducted for unwitnessed falls. Data collected on incident and accident forms are linked to the quality management system.</p> <p>The manger and unit nurse managers are aware of their requirement to notify relevant authorities in relation to essential notifications with examples provided (eg, Section 31 for RN staffing shortfalls).</p>

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<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies cover recruitment, selection, orientation and staff training and development. Nine staff files reviewed (two staff RNs, five caregivers, one-unit manager/RN, one EN) included evidence of a signed employment contract, job description relevant to the role the staff member is in, orientation, application form and reference checks. All files reviewed included annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position.</p> <p>A register of practising certificates for RNs and other health professionals is maintained within the facility to provide evidence of registration.</p> <p>There is an implemented annual education plan. There is an attendance register for each training session and an individual staff member record of training. Work is underway to improve attendance at mandatory in-service training. Registered nurses are supported to maintain their professional competency. Thirteen of thirty-nine nurses have completed their interRAI training. There are implemented competencies for registered nurses and caregivers related to specialised procedures and/or treatment including medication competencies and insulin competencies.</p> <p>Nineteen of twenty-one caregivers who work in the psychogeriatric unit have completed their dementia qualification. Two are recently employed and have not enrolled yet.</p> <p>There is a minimum of one staff available 24/7 with a current CPR/first aid certificate.</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>The facility has two rest home units (Kilgour and Dalkeith) with an occupancy of 38 beds during the audit. The psychogeriatric unit (Lindsay) was full with an occupancy of 24 beds, and two hospital units (Dunrowan and Craig) were also full with an occupancy of 60 beds.</p> <p>Four-unit nurse managers/RNs work five days a week with one-unit manager rotating weekends. The manager works Monday - Friday. The unit nurse managers and manager share after hours on call support for staff.</p> <p>The unit nurse manager for the two rest home units is supported by four caregivers on the morning shift (three long and one short shift). Four caregivers work on the afternoon shift (two long and two short shift), and two caregivers work night duty (one in each unit). The RNs in the hospital units cover the rest home units in the afternoon and at night.</p> <p>There is a registered nurse on duty for the psychogeriatric unit on each shift, seven days per week. The registered nurse on duty on the morning shift is supported by five caregivers (three long and two short shift). In the afternoons, the RN is supported by four caregivers (one long and three short shift). On night duty there is an RN and caregiver on duty.</p> <p>The unit manager in Dunrowan unit (hospital wing) is supported by a registered nurse, enrolled nurse and seven caregivers on the morning shifts (four long and three short shift). In the afternoon there is a registered nurse,</p>

		<p>enrolled nurse and four caregivers on duty (one long and three short shift). At night, there is one registered nurse and one caregiver on duty.</p> <p>The unit nurse manager in Craig unit (hospital wing) is supported by a registered nurse on each shift and an enrolled nurse (short shift). Five caregivers are on duty in the morning (two long and three short shift), four on the afternoon shift (one long and three short shift) and one caregiver supports the RN on night duty.</p> <p>Staff, residents and relatives interviewed confirmed that staffing levels are adequate, and that management are visible and able to be contacted at any time. Residents reported that call bells are answered promptly.</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>	<p>FA</p>	<p>Ross home and hospital uses an electronic medication management system. They are in the process of moving from blister packed medication to robotic sachet packed medications. Registered nurses administer medications to hospital and psychogeriatric residents, with either enrolled nurses, medication competent caregivers or a registered nurse administering medications in the rest home wings. All staff who administer medications are deemed competent to do so. Policies and procedures support practice and training has been provided. Self-administration by residents is managed as per guidelines and policy. The GP interviewed advised that three monthly medication reviews are completed and minimal attitude to anti-psychotic medication is adhered to. Staff were observed safely administering medications on the days of audit.</p> <p>Fourteen electronic medication files were reviewed (five rest home, five hospital and four psychogeriatric). All files reviewed evidenced the resident's photograph, allergy status and correct prescribing. A rest home respite resident had a paper-based medication chart and signing sheet which was also completed appropriately.</p> <p>'As required' medication was appropriately prescribed and administered, and effectiveness noted in either the comments section or the progress notes section of the electronic resident management system.</p> <p>Storage of medications including refrigeration and controlled medications, were correctly managed and documented in the five medication rooms. Medications were within expiration and eye drops were dated.</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</p>	<p>FA</p>	<p>Ross home and hospital has a large, well-equipped kitchen where all meals and snacks are prepared. The food services manager was absent on the days of audit; however, the cook interviewed was able to discuss the food service and was knowledgeable regarding the current menu and all aspects of food service. The menus are reviewed six monthly by the PSO dietitian. Food service management meetings for all PSO homes is chaired by the Ross home manager. Food service staff are trained in food safety. The chiller and freezer temperatures are recorded daily, and food temperatures are recorded at each mealtime.</p> <p>Residents and family members interviewed expressed satisfaction with the meals and individual likes, dislikes and preferences are catered for. Food profiles, dietary needs and allergies are recorded. Weight monitoring occurs</p>

<p>service is a component of service delivery.</p>		<p>and the dietitian becomes involved with any residents who are experiencing weight loss. Supplements and fortified meals are provided to those residents requiring these. Special equipment was observed to be in use. A Food Control Plan is in place and local council verification has occurred with a current annual certificate displayed.</p> <p>The café in Ross home is available to residents, families and staff. Additional food and snacks are available from the kitchen at any time of the day or night.</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 care being provided for residents is consistent with the needs of the residents, as evidenced through review of resident files, interviews with staff and residents and observation of practice. Residents who required registered nurse review following health concerns had this recorded as having been done. Relatives were notified of changes in a resident's condition as evidenced in progress notes, event reports and family interviews. The registered nurses initiate a GP consultation for any changes in resident health status. Caregivers document any changes in care/condition of residents in the progress notes. The resident records reviewed were individualised and personalised to meet the assessed needs of the residents. The care was flexible and focused on promoting quality of life for the residents. All residents interviewed reported satisfaction with the care and service delivery.</p> <p>Wound care documentation was in place for all residents with wounds. A wound register is available on the electronic resident management system. There were three pressure injuries. Nurses have access to external support from dietitian, occupational therapist, physiotherapist, continence nurse and wound care specialist. There were adequate dressing and continence supplies sighted on the day of audit.</p> <p>On interview, staff confirmed they were familiar with the current interventions of the residents. Electronic monitoring records were completed for weight, observations, bowel management, restraint and food and fluids.</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>Ross Home continues to employ six activity staff (three diversional therapists, and three activities coordinators). The activity team rotates to each wing including a day in the weekend. Two activities coordinators work a 6-8 pm shift to cover in the psychogeriatric unit. 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 were included in the programmes. Activities programmes include the Enliven philosophy and resident's activity participation notes were reflective of this philosophy. Activities staff advised that residents have input into the activities programme and links to the community are a focus of the programme. Activities include going out for meals, shopping, bowls, concerts, visiting school groups, music and entertainment and cooking.</p> <p>Van outings are provided for residents once a week for each wing and twice a week for the psychogeriatric unit. Resident and family interviewed, and consumer surveys showed satisfaction with the activities programme. A large group of volunteers also contribute to the lives of the residents through the activities programme.</p>

		<p>Resident's individual activity plans were 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.</p> <p>Staff were observed interacting with residents, and in the psychogeriatric unit were using diversion strategies for residents who required this.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Progress notes were written in the electronic resident management system every shift for the resident files reviewed. Registered nurses reviewed progress notes and provided oversight to the enrolled nurse in one of the rest homes wings. Short-term care plans were documented and evaluated when resolved. Lifestyle support plans were recorded and reviewed six monthly. Medical and medication reviews were conducted by the GP three monthly. Family were invited to attend the three-monthly reviews, and if not able to, are provided with a record of the meeting. The resident files reviewed evidenced six-monthly care plan reviews with changes made to lifestyle support plans if this was required. InterRAI assessments had been completed following a significant change in level of care (one hospital and one psychogeriatric file reviewed).</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>	FA	<p>A current building warrant of fitness is posted in a visible location (expiry 4 December 2019). The maintenance person was unavailable during the audit. The environment and buildings are well maintained. The service has a lift which operates between floors and lift maintenance and the compliance certificate is maintained as part of the building warrant of fitness. The testing and tagging of equipment and calibration of medical equipment were current and records were maintained. Hot water at the tap is maintained at a safe temperature, with regular monitoring occurring.</p> <p>Corridors are wide enough and allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment.</p> <p>There are many small and moderate sized outside courtyard areas with seating, tables and umbrellas available. Pathways, seating and grounds were well maintained. Appropriately secured handrails were provided in the toilet/shower areas, and other equipment/accessories were available to promote resident independence.</p> <p>In the psychogeriatric unit, the lounge area is designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required. There is a safe and secure outside area that is easy to access.</p> <p>Interviews with staff confirmed there was adequate equipment.</p>
Standard 3.5:	FA	The infection control nurse (rest home unit manager) accesses information from the electronic resident

<p>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>management system to track the incidence and nature of infections. This data is also collated by the PSO quality manager and graphs and data summaries are provided to each facility. Education is provided to staff and corrective actions are developed following collation of data.</p> <p>Changes in the past year to benchmarking data and key performance indicators has meant that comparisons with previous audit continuous improvement has not been possible, therefore the previous CI is not upheld. For example, comparing current urinary tract infection rates with new benchmarking criteria indicates that the service is tracking above the expected reference range. Benchmarked data is provided to the facility on a quarterly basis with comparisons made to other PSO facilities. A register of infections is accessed from electronic records.</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>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were eight residents (three hospital and five psychogeriatric) with restraint (bed rails, lab belts, attached tables) and no residents who had requested enablers.</p> <p>Staff training is provided annually around restraint minimisation and managing of challenging behaviours. Staff interviews confirmed their understanding of the difference between an enabler and a restraint.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely</p>	PA Moderate	<p>Initial assessments, risk assessments and initial care plans were completed within required timeframes for all residents on the files reviewed. Lifestyle support plans were also completed for six of seven files reviewed. Community based interRAI assessments were completed for five of seven files reviewed. One resident under a long-term health condition contract did not have interRAI completed as this was not required. One rest home respite resident had a care plan completed for the duration of their stay. InterRAI assessments were completed for four of seven residents. One new hospital resident was within the three-week timeframe for having their interRAI assessment completed. Of the remaining four resident files reviewed, two of four files had not been completed within the prescribed timeframes for admission. Six monthly re-assessments had been completed. This aspect of the previous finding has been met. The sample size was increased, and a further five files were reviewed in respect to interRAI assessments. Of these, three were also not completed within the required timeframe.</p>	<p>Five of nine interRAI assessments reviewed were not completed within 21 days of admission.</p>	<p>Ensure interRAI assessments are completed within 21 days of admission.</p> <p>90 days</p>

meet the needs of the consumer.				
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Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	CI	<p>Residents and family are provided with information on entry to the service. The service continues to update and inform residents/family/EPOA when there are any changes to resident health or needs. Information is provided through a variety of methods including; residents and family meetings, one-on-one conversations, written letters, email and telephone.</p>	<p>The service has set up the option for families to be part of the multi-disciplinary review meetings with the GP and unit manager. This has been enhanced since the previous audit whereby families are now connected via video conferencing (vs. audio only).</p> <p>Family members reported that the ability to teleconference with the care team has improved communication and they felt included in the review process rather than being informed of an outcome, when staff emailed or telephoned them after the multidisciplinary meeting (health and wellbeing review) when this had been completed in the past. This previous area identified as a continuous improvement remains in place.</p>

End of the report.