# Lister Home Incorporated - Lister Home

## Introduction

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

The audit has been conducted by 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:

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| **Legal entity:** | Lister Home Incorporated |
| **Premises audited:** | Lister Home |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | Start date: 21 November 2019 End date: 22 November 2019 |

**Proposed changes to current services (if any):** One previously decommissioned bedroom used for office space has been reconfigured back into a bedroom increasing the total number of beds from 62 to 63.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 56

# 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 |
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| | 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 |
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| | 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

Lister home and hospital is governed by a community trust board, comprised of representatives from all local churches in Waimate. The service provides care for up to 63 residents at hospital (geriatric and medical) and rest home level care. This includes one bed designated for respite care and one bed designated for palliative care. On the day of the audit there were 56 residents.

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, relatives, staff, the GP and management.

The non-clinical manager has been in the role for 11 months, she is supported by an experienced clinical manager (RN), registered nurses, an enrolled nurse and long-standing caregivers.

The three previous audit shortfalls around quality documentation, education and service delivery implementation continue to require improvement.

This surveillance audit identified shortfalls around communication, incident reporting, RN documentation and temperatures.

## Consumer rights

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| 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. |

The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place. Relatives interviewed felt they were updated promptly of all adverse events.

## Organisational management

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| 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. |

Lister home and hospital has a documented quality and risk management system that supports the provision of clinical care and support. A resident satisfaction survey has been completed in 2019. There are regular resident/relative meetings. Incidents are documented. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

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| 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. |

Registered nurses are responsible for care plan documentation. InterRAI assessments and care plans are completed and reviewed within required timeframes. Planned activities are appropriate to the resident's assessed needs and abilities. Residents and relatives were satisfied with the activities programme. The service uses an electronic medication management system. 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

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| 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 building warrant of fitness. Preventative and reactive maintenance occurs. The facility is spacious and provides adequate space for residents to access all communal areas using mobility aids. The external gardens are well maintained and accessible to all residents.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |

The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. At the time of the audit there were eight residents requiring restraints and one resident using an enabler. Staff training has been held for management of challenging behaviours.

## Infection prevention and control

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| 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. |

Lister Home continues to implement their infection surveillance programme. Infection control issues are discussed at both in the infection control and quality/staff meetings. The infection control programme is linked with the quality programme. A recent viral outbreak was managed well, notifications were made 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) |
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| **Standards** | 0 | 9 | 0 | 3 | 4 | 0 | 0 |
| **Criteria** | 0 | 34 | 0 | 3 | 4 | 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) |
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| **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 |
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| Standard 1.1.13: Complaints Management<br>The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Complaints forms are available at the entrance to the facility. Information around the complaints process is provided on admission. A record of all complaints, both verbal and written is maintained by the facility manager on the complaints register. Five complaints have been received since the last audit; two in 2018 and three in 2019. Documentation and correspondence reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. The staff interviewed could describe directing the complainant to the most senior person on duty. Residents and relatives advised that they are aware of the complaints procedure and how to access forms. The relatives interviewed stated they feel comfortable discussing concerns with the management. |
| Standard 1.1.9: Communication<br>Service providers communicate effectively with consumers and provide an environment conducive to effective | PA Low | Comprehensive information is provided at entry to residents and family/whānau. Five residents (three hospital and two rest home) interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. Both the facility manager and clinical manager were available to residents and relatives and they promote an open-door policy. The two relatives (one rest home, one hospital) interviewed advised that they are notified of incidents and when residents' health status changes promptly. The staff (one registered nurse, one enrolled nurse, four caregivers, one kitchen manager one maintenance man, and the diversional therapist) interviewed, fluently described instances where relatives would be notified, however not all ten incident reports reviewed documented relative notifications. Interpreter services are |

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| communication. | | available if required. |
| Standard 1.2.1: Governance<br><br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Lister Home and Hospital is governed by a community trust board, comprised of representatives from all local churches in Waimate. The service provides care for up to 63 residents at hospital (geriatric and medical) and rest home level care. One room previously used as an office space is now used as a bedroom again. The facility manager advised she notified MOH. There is one bedroom designated for respite care, a palliative care suite and up to seven dual-purpose beds.<br><br>On the day of the audit, there were 56 residents in total – 27 at rest home level (including two under mental health contracts, one under a residential physical disability contract and one on carer support, and one respite) and 29 hospital level (including one on a long-term support – chronic health contract (LTS-CHC) and one younger person on a disability (YPD) contract).<br><br>The service has a strategic plan, a quality and risk plan, and a risk and management plan documented. Organisation goals are documented and reflect the philosophy of this Christian-based organisation.<br><br>The facility manager reports to the board monthly, against the quality and risk plans and on a variety of operational issues. The clinical manager reports on clinical matters.<br><br>Lister Home is managed by a non-clinical facility manager who has been in the role since January 2019. She has a background in financial consulting and was a business lecturer at ARA. The manager is supported by a clinical manager (RN), who has worked at the facility for 17 years. She has been in the role for 17 months. An enrolled nurse (EN) who has worked at Lister Home for 23 years and manages the rest home area. They are supported by registered nurses and caregivers.<br><br>The nurse manager has completed a minimum of eight hours of professional development relating to the management of an aged care service in the past twelve months including attendance at the NZACA conference, attends the monthly DHB meetings and the compulsory education at the facility. The clinical manager attended the NZACA conference and completes in-house training sessions. |
| Standard 1.2.3: Quality And Risk Management Systems<br><br>The organisation has an established, documented, and maintained quality and risk management | PA Moderate | The quality plan for 2019 to 2020 is in place which includes the values, mission and philosophy of the service. Objectives for the year include maintaining the good reputation with the facility, investing in staff through reviewing the wage structure and increasing education and training opportunities. The facility manager and clinical manager report progress to the board and attend the board meetings on a monthly basis.<br><br>Internal audits have occurred according to the schedule in 2019; there was a catch-up period in late 2018 to compete all internal audits for the year. This is an improvement since the previous audit. All audit templates included corrective actions identified, which have been signed off as completed, however the results have not |

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| system that reflects continuous quality improvement principles. | | consistently been discussed at meetings. A recent external DHB contracts audit had been undertaken, the results were not available on the day of the audit.<br><br>The service has introduced the following quality initiatives since the last audit (but not limited to); working on purchasing of new equipment including hi/low beds; to reduce the use of restraint, installing ceiling hoists to resident rooms, and refurbishing lounge and dining areas. Staff have been fundraising to make improvements to the palliative care suite. There have been improvements to food services, including improving the dining experience, a review of the menu, meal presentation and reduction of food wastage. There have also been improvements made around laundry services.<br><br>There was no resident or relative satisfaction survey held in 2018, and the 2019 satisfaction survey had just occurred. The results were in the process of being collated at the time of the audit and showed overall satisfaction with the service.<br><br>The meeting structure for 2020 is under review. Meetings including RN/EN, unit (hospital and rest home) meetings and health and safety/infection control meetings have been held. However, these minutes do not consistently discuss quality data analysis and trends. This is an area that continues to require improvement. Advised that the minutes of all meetings are available in the staff room for all staff to read and sign, however the meetings have not been held according to schedule.<br><br>There are monthly accident/incident and infection reports provided and these were displayed in the staff room. There is a hazard management, health and safety, and risk management programme in place. There are facility goals around health and safety. The health and safety officer was interviewed. There is a designated health and safety committee who meet as part of the quality meetings. The hazard register is currently under review. Five health and safety representatives have completed external level 1 and 2 training.<br><br>Falls prevention strategies are in place including intentional rounding, post falls reviews and individual interventions. |
| Standard 1.2.4: Adverse Event Reporting<br><br>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 | PA Moderate | The service documents and analyses all incidents/accidents. All incident forms are reviewed and collated monthly. A report is provided to the board monthly, and also posted on the staffroom noticeboards (link 1.2.3.6). Ten resident related incident/accident forms were reviewed. Individual incident reports have been completed for each incident/accident, with immediate action noted and individual resident risks were documented as followed up. The incident/accident forms reviewed did not always document immediate follow-up by a RN including completion. Neurological observations were documented for all unwitnessed falls or falls with a possible head injury. This is an improvement since the previous audit.<br><br>Discussions with the facility manager, confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. There had been seven section 31 notifications for two intruders entering the building, influenza outbreaks, an RN shortage, three stage 3 pressure injuries (one facility acquired), and an |

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| in an open manner. | | instance when money was stolen. |
| Standard 1.2.7: Human Resource Management<br><br>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Moderate | There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Six staff files were reviewed (three registered nurses - morning, afternoon and night, one activities coordinator, a kitchenhand and a night caregiver). All had relevant documentation relating to employment, however not all staff had current appraisals.<br><br>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.<br><br>There is an education plan that is being implemented that exceeds eight hours annually; however, does not include all compulsory education required. The previous shortfall continues to require improvement. There is evidence in the registered nurse files of attendance at the DHB external training. Interviews with caregivers confirmed participation in the Careerforce training programme. A competency programme is in place that includes annual medication competency for staff administering medications. Core competencies are completed, and a record of completion is maintained and signed. Competency questionnaires were sighted in reviewed files. The enrolled nurse and two RNs are trained in interRAI.<br><br>There are four caregivers and one activities coordinator completing level 4 Careerforce training. Nine caregivers are completing level 3 and three are completing level 2 Careerforce training. All nurses and senior caregivers have a current first aid certificate, the previous finding has been addressed. |
| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Lister Home has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.<br><br>The facility manager and clinical manager work five days a week Monday to Friday.<br><br>Rest Home 29 beds (28 residents including two on mental health contracts and six hospital level).<br><br>The enrolled nurse works Monday to Friday. A senior caregiver is on duty over the weekends with oversight from the hospital RN.<br><br>They are supported by four caregivers rostered on the morning shift; 1x 7 am to 3.30 pm, 2x 7.30 am to 1 pm and 1x 8.30 am to 11 am.<br><br>The afternoon shift is covered by three caregivers; 1x 3.15 pm to 11.15 pm, 1x 4.30 pm to 8.30 pm, and 1x 5 pm to 8 pm. |

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| | | Hospital 32 beds (29 residents including one YPD, one LTS-CHC, and two rest home level).<br><br>A registered nurse is rostered across all shifts.<br><br>They are supported by six caregivers on the morning shift; 1x 6.45 am to 3.15 pm, 1x 6.45 am to 3 pm, 2x 7.30 am to 1 pm, and 2x 8.30 am to 1 pm.<br><br>The afternoon shift has five caregivers rostered; 1x 2.45 pm to 11.15 pm, 1x 3.30 pm to 9.30 pm, 1x 5 pm to 11.15 pm, 2x 5 pm to 8 pm.<br><br>The night shift is covered by one RN and two caregivers (one in each wing) from 10.45 pm to 7.15 am.<br><br>Interviews with the registered nurse, caregivers and residents confirmed that there are sufficient staff to meet care needs. |
| Standard 1.3.12: Medicine Management<br><br>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | Lister Home have implemented an electronic medication management system. The supplying pharmacy couriers all medicines in blister packs for regular and 'as required' medications. Medications were checked and signed on arrival from the pharmacy.<br><br>Registered nurses and senior caregivers are assessed as medication competent to administer medication. Five RNs have completed syringe driver training. The three who have not are booked in for the next session available. Standing orders were not in use. The medication fridge temperatures have been monitored daily by the maintenance person, however not always in the rest home area. Medication room temperatures were recorded at 22 degrees Celsius.<br><br>Ten electronic medication files were reviewed. Medication reviews were completed by the GP three monthly. 'As required' medications were prescribed correctly with indications for use. Medications are stored securely in the locked nurses' station in the rest home area and a locked medication room for the hospital wings. Controlled drug medications were appropriately stored. There were no self-medicating residents. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals at Lister Home are prepared and cooked on-site. They are transported to the smaller dining rooms and lounges in hot boxes from which the staff serve the meals. There is a four-weekly seasonal menu which has been reviewed in November 2019. There is a verified food control plan, completed by the local council. Fridge, freezer and chiller temperatures are taken and recorded daily. End-cooked food temperatures are recorded daily. The dishwasher is checked regularly by the chemical supplier. Fridge temperatures are recorded for the fridges in each resident dining/servery area. All food services staff have completed training in food safety and hygiene and chemical safety.<br><br>The kitchen staff were aware of all resident's special dietary requirements on the day of audit. The cook is |

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| | | aware if residents are losing weight or not enjoying meals and she discusses with them or their families what food they would prefer, and this is provided. The kitchen manager had input from the dietitian around provision of diets for medical conditions such as diverticulitis. Supplements are provided to residents with identified weight loss issues. Individual resident likes, and dislikes are accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met.<br><br>Staff were observed assisting residents with their meals and drinks. Resident meetings and surveys allow the opportunity for resident feedback on the meals and food services generally. The kitchen manager stated the residents also regularly provide verbal feedback. Residents and relatives interviewed were very complimentary about the food and confirmed alternative food choices were offered for dislikes. |
| Standard 1.3.6: Service Delivery/Interventions<br><br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | When a resident's condition alters, a registered nurse initiates a review and if required, GP, nurse specialist consultation. The caregivers follow the care plan and report progress at the end of each shift. The relatives interviewed stated they were notified of any changes to their relative's health. Short-term care plans were used for short term/acute changes in care. These were in place for infections in the resident files reviewed. A review of five resident files identified goals and interventions; however, there were no interventions in place for a resident using restraint, and risks of restraint use was not identified.<br><br>Neurological observations had been completed for unwitnessed falls where there was a possibility of a head injury. This previous shortfall has been addressed.<br><br>There were four wounds on the day of the audit including three chronic wounds and one stage 2 facility acquired pressure injury. The district nurses were visiting to review this wound, and the GP had reviewed the wound and progression. All wounds had individual wound assessments, plans and evaluations which indicated progression or deterioration of the wounds. Adequate dressing supplies were sighted in treatment rooms.<br><br>Continence products were available and resident files included a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly or more frequently if weight is of concern.<br><br>Monitoring forms were used for weight and vital signs, blood sugar levels, pain, challenging behaviour, and food and fluid charts. |
| Standard 1.3.7: Planned Activities<br><br>Where specified as part of the service delivery | FA | There is one diversional therapist and two activities coordinators who lead the activities programme over seven days a week. The activities team have first aid certificates. Activities assessments and the social profile are completed with family input two weeks after admission to allow time for settling. An activities plan is created with the resident (as appropriate) with resident-centred goals. The plan is evaluated six monthly. An activities attendance record for each resident is maintained and added to the resident files two monthly. Each member of |

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| plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | | the team has a 'document' day to ensure records are maintained.<br><br>Activities are planned a month ahead and are printed weekly with a newsletter on the back of the weekly planner. Each resident has a copy of this for their reference. Daily activities are posted on noticeboards around the facility. One-on-one time with residents occurs, which was verified during resident interviews.<br><br>Regular activities include church services, exercises, craft, baking, group games, happy hours, newspaper reading, and quizzes. Afternoon activities are combined and held in the main lounge. There are entertainers (sighted during the audit) and guest speakers who visit the facility. The residents recently were part of a market day to raise money for the sensory garden for the palliative suite. Activities for younger residents are very resident-centred. Younger residents interviewed stated they are encouraged to be active within the community and can participate in group activities in house, and they have the opportunity for one-on-one activities of their choice. Van outings occur more often in the summertime and include going out for afternoon tea, and shopping trips.<br><br>Resident meetings are held every four months. The residents provide verbal feedback and suggestions as they arise. The residents interviewed expressed satisfaction with the current activities programme. |
| Standard 1.3.8: Evaluation<br><br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Initial care plans reviewed for long-term residents were evaluated by the clinical manager, registered nurse or enrolled nurse (under RN supervision) within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by the clinical manager or nurses six monthly, using the interRAI tool or earlier for any health changes for files reviewed. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes or the care plan. The short-term care plans have been reviewed and evaluated |
| Standard 1.4.2: Facility Specifications<br><br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current warrant of fitness expiring on 1 August 2020. Preventative and reactive maintenance occurs, and records are maintained. Hot water temperatures are checked randomly and were within ranges. Tradesmen are available if required. Equipment has been tagged and tested.<br><br>All areas are accessible for residents using mobility aids. There are communal lounge areas within each wing, with large communal lounge and dining areas in the hospital and rest home wings. Corridors are wide with large floor to ceiling windows and seating areas for residents to enjoy.<br><br>Outdoor areas and gardens are manicured and accessible to residents. One area has raised gardens where residents grow vegetables. The gardens have seating and shade provided.<br><br>One previously decommissioned resident bedroom used for office space, has been reconfigured into a bedroom. The room is spacious with an ensuite and built-in wardrobe. Call bells are in place and there is |

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| | | adequate space for the use of equipment and mobility aids.<br><br>The caregivers interviewed stated they have sufficient equipment including mobility aids, wheelchairs and pressure injury equipment (if required), to safely deliver the cares as outlined in the residents' care plans. |
| Standard 3.5: Surveillance<br><br>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Lister Home continues to implement their infection surveillance programme. Individual infection alert forms were completed for all infections. Infections were included on a monthly register and a monthly report and graphs were completed by the infection control coordinator (registered nurse). Infection control (IC) issues are discussed at the combined quality and staff meetings, however there was no evidence of discussing trends (link 1.2.3.6). In-service education is provided annually and in toolbox talks when required.<br><br>There has been one recent viral outbreak, notifications were made in a timely manner, and logs were maintained. |
| Standard 2.1.1: Restraint minimisation<br><br>Services demonstrate that the use of restraint is actively minimised. | FA | Restraint practices are only used where it is clinically indicated, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. The clinical manager is the restraint coordinator.<br><br>At the time of the audit there were eight residents using restraints; four residents using bedrails and four using lap belts on wheelchairs. One of the residents is using both bedrails and a lap belt. There was one resident using a bedrail as an enabler. Monitoring charts were in place and maintained, overall the use of restraint is linked to the care plan (link 1.3.6.1). Staff training has been held for management of challenging behaviours, however there has been no restraint education sessions held (link 1.2.7.5). |

# 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) |
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| Criterion 1.1.9.1<br>Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | The residents, relatives and staff stated there was a good flow of information between the facility and staff. Relatives visit regularly, and feel the staff are prompt at reporting adverse events, however, this was not well documented either on the incident reports or progress notes. | Four of ten incident reports did not evidence NOK notification or reason why not notified. | Ensure documentation of notifications is clearly documented.<br><br>90 days |
| Criterion 1.2.3.6<br>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | The have been meetings held sporadically throughout the year. Nurses and caregivers interviewed confirmed minutes are available to staff on noticeboards. Current infections and precautions are discussed at handovers; however, there was no documentation around discussions around trending of quality data including results and corrective actions of internal audits. This is an ongoing shortfall. | i) Meetings have not been held according to schedule including RN/EN, quality, restraint, unit meetings, and department meetings.<br>ii) Meeting minutes do not consistently reflect | Ensure meetings are held according to schedule and reflect discussions around quality data, trending and analysis. |

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| | | | discussions around trending and analysis of quality data or results of internal audits. | 90 days |
| Criterion 1.2.4.3<br>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | Clinical staff interviewed confirmed all adverse events are discussed at handovers; and describe the process around documentation. However, clinical follow up is not well documented on the incident reports or in the progress notes. | Four of ten incident reports did not evidence RN follow-up following falls (including one unwitnessed fall) either documented in progress notes or incident report. | Ensure adverse events (especially falls) have clinical follow-up documented appropriately.<br><br>90 days |
| Criterion 1.2.7.5<br>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | Education has occurred in 2019, a compulsory study day was held in October 2019; however, did not include all required education sessions. The previous shortfall continues to require improvement. There is no evidence of appraisals occurring in 2018, a catch-up programme was in place by management. | (i). There was no evidence of training sessions for abuse and neglect, falls, restraint, sexuality, pain and aging process. (ii). Five of six staff files reviewed did not have a current appraisal in place. | (i). Ensure all required education sessions are held and included in the education planner. (ii). Ensure all staff have an appraisal completed annually<br><br>60 days |
| Criterion 1.3.12.1<br>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 | PA Low | Temperatures for the rooms and fridges are recorded by the maintenance person and were within acceptable range in the hospital wing. However, the rest home thermometer was not working on the day of the audit. This was rectified at the time. | The medication fridge thermometer on the rest home wing was not working on the day of the audit. | Ensure staff monitor the temperature of the medication fridges regularly. |

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| with legislation, protocols, and guidelines. | | | | 90 days |
| Criterion 1.3.3.4<br>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Low | Progress notes were completed by the caregivers at least daily for the rest home resident and at the end of each shift for hospital residents, however, not all registered nurses were documented within timeframes. | There were gaps in RN progress notes for up to four days in two of three hospital files | Ensure RNs are documenting progress notes in line with policy<br><br>90 days |
| Criterion 1.3.6.1<br>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Overall the care plans reviewed included information and instructions for caregivers to provide care for the residents. The caregivers interviewed felt there was sufficient information in the care plans to guide them to provide care for the residents. However not all interventions or risks were identified for the use of restraints.<br>Short-term care plans were in use for short-term needs and had been reviewed and either resolved or transferred to the long-term care plans as required. | (i) Three of three restraint files did not have risks identified.<br>(ii) One of three restraint files had no interventions around the use of restraint documented. | (i)-(ii) Ensure care plans for restraint identify risks associated and contain interventions around usage and monitoring requirements.<br><br>90 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.

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End of the report.