# Trinity Home and Hospital Limited - Trinity 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 Q-Audit Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

| | |
|---|---|
| **Legal entity:** | Trinity Home and Hospital Limited |
| **Premises audited:** | Trinity Home & Hospital |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| **Dates of audit:** | Start date: 13 April 2021 End date: 14 April 2021 |

**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:** 72

# 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

Trinity Home and Hospital provides rest home-level care for up to 78 residents. There were 72 residents at the facility on the first day of the audit.

This certification audit was conducted against the relevant Health and Disability Services Standards and the service contract with the district health board.

The audit process included a review of policies and procedures, a review of resident and staff files, observations, and interviews with residents, family members, management, staff, and a physiotherapist.

The residents and family members spoke positively about the care provided.

Areas requiring improvement are identified relating to quality and risk management, adverse event reporting, and service delivery/interventions.

The three previous corrective actions relating to quality and risk management, human resources, and medication management are closed.

## 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. |

Open communication between staff, residents, and families is promoted. There is access to interpreting services if required.

A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

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

The Trinity trustees are responsible for the services provided at this facility. A Trinity Home and Hospital board of directors provides governance. There are systems in place for monitoring the services provided, including regular monthly reporting to the board of directors.

A general manager oversees the facility with a clinical nurse manager and a clinical nurse leader overseeing clinical services.

There is an internal audit programme, risks are identified, and a hazard register is in place. Adverse events are documented on accident/incident forms. Facility meetings are held and there is reporting on various clinical indicators, quality and risk issues, and discussion of identified trends.

There are policies and procedures on human resource management. A mandatory programme is provided for staff.

There is a documented rationale for determining staffing levels and skill mixes that is based on best practice.

## 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. |

Registered nurses assess residents on admission. The initial care plan guides care and service provision during the first three weeks after admission.

The interRAI assessment is used to identify residents' needs; these are completed within the required timeframes. The general practitioner completes a medical assessment on admission and reviews occur thereafter on a regular basis.

Long term care plans are developed and implemented within the required timeframes, they are individualised and based on an integrated range of clinical information. Residents' needs, goals and outcomes are identified. All residents' files reviewed demonstrated evaluations were completed at least six-monthly. Residents and their relatives are involved in the care planning process and notified regarding any changes in a resident's health status.

Short term care plans are in place to manage short term issues or problems as they arise.  Handovers between shifts guide continuity of care and teamwork is encouraged.

An electronic medication management system is in place. Medication management is in line with legislative and contractual requirements. Medications are administered by registered nurses and caregivers who have completed current medication competency requirements.

The activity programme is managed by two diversional therapists. The programme provides residents with a variety of individual and group activities and maintains their links with the community. The service uses its facility van for outings in the community.

The food service meets the nutritional needs of the residents. All meals are prepared on-site. The service has a current food control plan. Kitchen staff have food safety qualifications.

## 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 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. | | Standards applicable to this service fully attained. |

Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the restraint coordinator who is a registered nurse. On the day of the on-site audit one restraint and four enablers were in use. Restraint is only used as a last resort when all other options have been explored. Enablers are voluntary.

## 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 appropriate to the size and complexity of the service. The infection control nurse is a registered nurse. Infection data is collated, analysed and trended. Monthly surveillance data is reported to staff. There has been one outbreak since the previous audit.

## Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|---|---|---|---|---|---|---|---|
| **Standards** | 0 | 13 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 2 | 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<br>The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. Systems are in place that ensure residents and their families are advised of the complaint process and the Code on entry to the facility. The complaints forms are displayed and accessible within the facility. Staff interviewed confirmed their awareness of the complaints process.<br>The general manager (GM) is responsible for complaints management.<br>The complaints register reviewed showed that six written complaints have been received over the past year and that actions taken are documented and completed within the time frames. Action plans show any required follow-up and improvements have been made where possible.<br>The GM advised that there are currently two complaints with the Health and Disciplinary Commissioner (HDC), dated March and April 2021. Both are currently under investigation. Information was supplied when requested in a timely manner.<br>There are no other complaints with other external agencies. |
| Standard 1.1.9: Communication | FA | Residents' records reviewed, confirmed that residents were kept informed about any changes to their status. Residents and family interviewed stated that they were advised in a timely manner about any urgent |

| | | |
|---|---|---|
| Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | | medical reviews or unexpected care situations.<br><br>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Health and Disability Services Consumers Rights (the Code).<br><br>Residents and family members are informed of residents' upcoming meetings. The resident meeting minutes reviewed evidenced that relevant information is shared.<br><br>Residents and family members can access the Trinity H&H private Instagram account for relevant information at any time regarding changes. Residents have access to ipads for face time conversations with family members.<br><br>Residents' need for interpreting services is discussed at the time of entry to services. Access to interpreters is organised through families, community groups, or the district health board. |
| 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 | Trinity Home and Hospital (Trinity H&H) is owned by a parent body of elected seven volunteer trustees/ shareholders, who ensure the constitution of the trust are adhered to. A board of six elected directors and a chairperson provides governance for the facility. The board of directors meets monthly, meeting minutes sighted. The chairperson meets the general manager weekly to discuss operational management such as staffing and financial issues, verified at an interview with the chairperson.<br><br>The strategic plan is a living document that outlines the purpose, values, scope, direction, and goals of the organisation. The organisation's values were visible on display at the entrance to the facility.<br><br>A GM is responsible for the overall management of the facility and has been in this position for over 15 years. The GM is a registered nurse (RN) but does not have an annual practicing certificate and has extensive experience in the management of residential care facilities.<br><br>The GM is supported in the role by a clinical nurse manager (CNM) who is responsible for the oversight of clinical services and has been in the position for two years. The CNM is supported by a clinical nurse leader (CNL). Both clinical leaders are RNs with current practicing certificates.<br><br>The facility can provide rest home, hospital level, and dementia care for up to 78 residents.<br><br>The facility has 9 rest home beds, 24 dementia care beds, and 45 dual-purpose level care beds. At the time of the audit, there were a total of 72 residents in the facility, 28 receiving rest home care, 21 hospital-level care, and 23 dementia (grade 3) care.<br><br>The service holds contracts with the DHB for rest home, secure dementia, hospital, medical/geriatric , and respite care.<br><br>There were two residents receiving care under the 65 years of age at audit, one at rest-home and one at |

| | | |
|---|---|---|
| | | hospital-level care, who is privately paying.<br><br>There were no respite care residents at the time of the audit. |
| Standard 1.2.3: Quality And Risk Management Systems<br><br>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | Trinity Home and hospital (Trinity H&H) has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents, including infections.<br><br>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the combined team meeting. Minutes however, did not evidence who was to complete the action and the timeframe when this was to occur.<br><br>Staff reported their involvement in quality and risk management activities through audit activities, Relevant corrective actions are developed and implemented, and evaluated to address any shortfalls.<br><br>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and removal of obsolete documents.<br><br>The internal audit programme is documented and implemented as scheduled. Audit data is collated, analysed, and evaluated. Where improvements are required following internal audits, corrective action plans are developed and implemented. One example sighted at the audit relates to the process of missing residents, it was noted there was no document that informed staff as to the process. A new form was developed and implemented. Evaluation of the new form evidenced a clear process for documentation of events with staff reporting the new form clearly defines the process. The previous corrective action is closed.<br><br>Health and safety policies and procedures are documented along with a hazard management programme. The CNM described the processes for the identification, monitoring, review, and reporting of risks and development of mitigation strategies. The GM is the health and safety officer and is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.<br><br>A current hazard register was sighted on-site. Staff interviewed confirmed awareness of the process to report hazards. |
| Standard 1.2.4: Adverse Event Reporting | PA Low | The essential notification of reported events is the responsibility of the GM. The GM and CNM demonstrated in interviews situations in which the service would need to report and notify statutory authorities including police attending the facility; unexpected deaths; sentinel events; notification of a |

| | | |
|---|---|---|
| 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. | | pressure injury, disease outbreaks, and changes in key managers. Staff interviewed understood the adverse event reporting process in relation to their professional practice and regulatory requirements. They were also able to describe the importance of reporting near misses. There have been three notifications to the ministry under Section 31 since the previous audit, two relating to missing residents and one pressure area.<br><br>Staff interviewed understood the adverse event reporting process in relation to their professional practice and regulatory requirements. There were also able to describe the importance of reporting near misses.<br><br>Staff who witness an event or are first to respond to an event, document the adverse, unplanned, or untoward accident/incident on the paper form. Results from accidents/incidents inform quality improvement processes and are discussed at facility meetings. However, not all unwitnessed falls evidence neurological observations had occurred. Family interviewed confirmed that they are notified where the resident has had an accident or a change in health status. |
| 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. | FA | Human resources management policies are based on good employment practices and relevant legislation.<br><br>Professional qualifications are validated, and there are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff and contractors that require them. The skills and knowledge required for each position are documented in a job description that outlines accountability, responsibilities, and authority. These were reviewed on staff files along with employment agreements, reference checks, performance appraisals, police vetting, and current first aid certificates. The previous corrective action is now closed.<br><br>Staff orientation includes all necessary components relevant to the role. Staff records reviewed show documentation of completed orientation.<br><br>The organisation has a documented role-specific mandatory annual education and training module/schedule. The mandatory continuing education included but was not limited to infection control, restraint/enabler use, moving, and handling. Interviews confirmed that all staff, including RNs, undertake relevant education per year and that an appraisal schedule is in place. Staff education records evidenced that ongoing training and education is completed.<br><br>There were five of the ten RNs identified as InterRAI competent. |
| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. |

| | | |
|---|---|---|
| appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | | Health care assistants staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.<br><br>An RN is rostered to cover all shifts, with all RNs having a current first-aid certificate.<br><br>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence.<br><br>The GM, and or the CNM or CNL are on call after hours and weekends seven days a week to support the facility with emergency matters. |
| 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. | FA | A current medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.<br><br>A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices in line with legislation, protocols and guidelines were observed. The required three-monthly reviews by the GP are recorded electronically.<br><br>The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. There are no standing orders used at the facility.<br><br>Review of the medication fridge evidenced that the service does not store or hold vaccines and interviews with the RN confirmed this. The medication refrigerator temperatures and medication room temperatures are monitored weekly.<br><br>Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration. Weekly checks and six monthly stocktakes of medications are conducted in line with policy and legislation.<br><br>The staff observed administering medication demonstrated knowledge and at interview demonstrated clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures. The RNs oversee the use of all pro re nata (PRN) medicines and documentation made regarding effectiveness on the electronic medication record and in the progress notes were sighted. Current medication competencies were evident in staff files.<br><br>There were two residents self-administering medication during the on-site audit. Safe storage was provided and sighted. A process is in place to ensure ongoing competency of the residents and self-medication is authorised by the GP |

| | | |
|---|---|---|
| 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 are prepared on site and served in the dining rooms or in the resident rooms if requested. The seasonal menu has been reviewed by a dietitian. The food control plan is current. Food management training and certificates for cooks and kitchen staff were sighted.<br><br>Food temperatures are monitored appropriately and recorded. The kitchen staff have relevant food hygiene and infection control training. The kitchen was observed to be clean, and the cleaning schedules sighted.<br><br>A nutritional assessment is undertaken for each resident on admission by the RN to identify the residents' dietary requirements and preferences. The dietary profiles are communicated to the kitchen staff and updated when a resident's dietary needs change and when dietary profiles are reviewed six-monthly. Diets are modified as needed and the cook interviewed confirmed awareness of the dietary needs, likes and dislikes of residents. These are accommodated in daily meal planning.<br><br>Residents were observed to be given sufficient time to eat their meal and assistance was provided when necessary. There were sufficient staff to ensure appropriate assistance was available. Residents and families interviewed stated that they were satisfied with the meals provided. Staff have access to food items over 24 hours to satisfy residents nutritional desires or needs.<br><br>All aspects of food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit comply with current legislation and guidelines. The cook is responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately in fridges, a freezer and cool store. Temperatures of fridges and the freezer are monitored and recorded daily. Dry food supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated. |
| 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 | Long-term care plans are completed by the RN and based on assessed needs, desired outcomes and goals of residents. Care planning includes specific interventions for long-term problems. Short-term care plans are in place for acute problems.<br><br>The GP documentation and records reviewed were current.<br><br>Physiotherapy input is provided weekly, the physiotherapist sees all new admissions, residents who have sustained a fall and for changes to moving and handling assessments.<br><br>Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs. There is evidence of wound care products available at the facility and where wounds required additional specialist input, this was initiated. However, assessment, treatment and evaluation of wounds does not comply with best practice. |

| | | |
|---|---|---|
| | | Monthly observations such as weight and blood pressure are completed and are up to date.<br><br>The nursing progress notes are recorded and maintained. Family communication is recorded on the family communication form. Interviews with residents and families confirmed that care and treatment met residents' needs. |
| Standard 1.3.7: Planned Activities<br><br>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 | The residents' activities programme is implemented by two diversional therapists. Activities for the residents are provided five days a week, Monday to Friday between 0830 and 1600. Caregivers in the dementia care wing incorporate activities and one-on-one time with residents as part of their role.<br><br>The activities programme was displayed on the resident noticeboards. The activities programme provides variety in the content and includes a range of activities which incorporate education, leisure, cultural, spiritual and community events. There are regular outings / drives for all residents as appropriate, weekly entertainment and involvement in community events. Regular church services are held in the facility chapel.<br><br>The residents' activities assessments are completed within three weeks of the residents' admission to the facility in conjunction with the admitting RN. Information on residents' interests, family and previous occupations are gathered during the interview with the resident and their family and documented. The residents' activity needs are reviewed six monthly at the same time the care plans are reviewed and are part of the formal six-monthly multidisciplinary review process.<br><br>Behaviour management plans for dementia care residents include de-escalation and redirection through use of one-on-one time and activities over a 24-hour period.<br><br>The residents and their families reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging in and enjoying a variety of activities. |
| Standard 1.3.8: Evaluation<br><br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it is reported to the RN.<br><br>Long term care plans are evaluated every six months in conjunction with the interRAI re-assessments or if there is a change in the resident's condition. Evaluations are documented by the RN. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Short term care plans are evaluated regularly and closed out once the acute problem is resolved.<br><br>Residents and families interviewed confirmed involvement in the evaluation process and any resulting changes. Contact with family was verified in the resident's records and documented in the individual |

| | | |
|---|---|---|
| | | resident files reviewed. |
| Standard 1.4.2: Facility Specifications<br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building of warrant of fitness compliance had been completed.<br>There have not been any structural alterations to the building since the last audit. |
| Standard 3.5: Surveillance<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 | The infection control policy describes the requirements for infection surveillance and includes the process for internal monitoring. Internal audits are completed. Surveillance data is collected in the clinical areas and collated monthly by the clinical manager.<br>There are two RNs with responsibility for IPC, they have completed training for the role.<br>Information following monthly infection data collection, analysis and trending is provided to staff through staff meetings.<br>New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Families are updated by phone, email or text if required. Short term care plans are developed to guide care and evaluate treatment for all residents who have an infection.<br>There was one outbreak in May 2020. Review of documentation evidenced this was managed and reported as required.<br>Covid-19 information is available to all visitors to the facility. MOH information was available on site. IPC resources were available should a resident infection or outbreak occur. There is an antimicrobial use policy. |
| Standard 2.1.1: Restraint minimisation<br>Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The clinical manager is the restraint coordinator, they provide support and oversight for enabler and restraint management at the facility.<br>On the day of audit there was one resident using restraint and four residents using enablers which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraint use.<br>Restraint is used as the last resort after all other alternatives have been tried. Use of enablers is voluntary. |

| | | |
|---|---|---|
| | | This was evident from documentation reviewed and staff interviews.<br><br>The restraint register was sighted. Restraint minimisation and safe practice education is provided to all staff at orientation/induction to the service and ongoing education is provided to staff annually. Review of restraint and enabler sue is completed and discussed at the RNs and combined staff meetings. |

# 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 1.2.3.5<br>Key components of service delivery shall be explicitly linked to the quality management system. | PA Low | Combined staff meetings are held monthly with an agreed agenda followed such as complaints, GM report, incidents/accidents, and audit results. Staff who do not attend the meeting minutes are requested to read and sign the attached sheet. Staff reported the meetings minutes are available to read in the staff room. | Meeting minutes define the action to be taken, however this does not include who is to complete or the timeframe when this is to occur. | Ensure meeting minutes actions define, who will complete and the time frame for completion.<br><br>180 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 | PA Low | Trinity H&H policy states all unwitnessed falls require neurological observations over a 24hour period. All accidents/incidents are collated and trended and reported through at staff meetings, this includes all unwitnessed falls. | Accident/incident records for residents who had unwitnessed falls, did not consistently evidence neurological observations had | Ensure accident/incident records for residents who experienced unwitnessed falls consistently record |

| | | | | |
|---|---|---|---|---|
| improve service delivery, and to identify and manage risk. | | | occurred over the 24 hours as per policy. | neurological observations as per policy.<br><br>180 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 | There is a record kept of all wounds in the facility and there is an adequate supply of wound care products available. However, in nine out of nine wound care plans reviewed documentation did not comply with best practice. All wounds are required to have an assessment, treatment plan and progress report. None of the wound care plans reviewed had these components completed correctly. Three chronic wounds had no photos and four wounds had photos taken but these were not dated. | Assessment, treatment and evaluation of wounds does not comply with policy and best practice | Ensure that all wound care complies with Trinity Home and Hospital wound care policy and best practice.<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.

| No data to display |
|---|

End of the report.