

Presbyterian Support Central - Reevedon Resthome

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 BSI Group New Zealand Ltd, 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 Central

Premises audited: Reevedon Resthome

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 8 March 2021 End date: 9 March 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: 34

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

Reevedon rest home is part of Presbyterian Support Central group and provides rest home level of care for up to 42 residents. On the day of audit, there were 34 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, management, staff and the general practitioner.

Residents interviewed commented positively on the care and services provided at Reevedon rest home.

The facility manager covers two local PSC sites and is supported by an experienced clinical nurse manager and has been in the role for four years.

There were no areas identified for improvement at this audit.

A continuous improvement has been awarded around the continued reduction in falls.

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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Policies are implemented to support residents' rights, communication and complaints management. Relatives are kept informed on resident's health status. There are regular newsletters, surveys and resident meetings providing an opportunity for feedback on the service. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

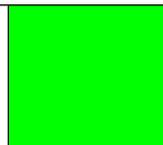
Organisational management

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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Reevedon rest home continues to implement the Presbyterian Support Services Central (PSC) quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly senior team meetings. Quality performance is reported to staff at meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation, staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

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.



Standards applicable to this service fully attained.

The registered nurses and enrolled nurse are responsible for the completion of assessments (including interRAI) and development of care plans and evaluations within the required timeframes. The care plans are updated with any changes to health status.

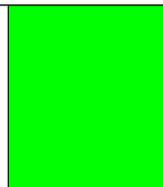
The seven-day week activity programme is resident-focused and provides group and individual activities planned around everyday activities such as walks, craft and gardening. Some activities are resident led and there are volunteers who assist with this programme.

There are medicine management policies and procedures in place. Medication is managed in line with current guidelines. The medication charts meet legislative prescribing requirements and are reviewed by the GP three monthly.

The dietitian reviews the menu. Food is cooked off-site at a local PSC site and transported to Reevedon. There are self-service meals in the dining room. Resident dislikes are accommodated. Residents commented positively on the meals provided.

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 and there is reactive and planned maintenance carried out.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is a restraint policy in place that states the organisation's philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit there were no residents with restraints or enablers. Minimisation, enabler use, and challenging behaviour training is included in the training programme.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control nurse (clinical nurse manager) uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene competencies and surveillance of infection control events and infections. Additional Covid-19 meetings and education was provided during the lockdown period and ongoing.

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	16	0	0	0	0	0
Criteria	1	40	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice, and this is communicated to residents and family members. A copy of the complaint procedure is provided to residents within the information pack at entry. The facility manager leads the investigation and management of complaints (verbal and written). A complaint's register records activity. Complaint forms and advocacy brochures are visible at the main entrance. There has been one internal complaint that was received at head office and forwarded to the clinical manager for investigation. The complaint was resolved to the satisfaction of the complainant.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	FA	There is an open disclosure policy. Six residents interviewed stated they were kept informed on facility and health matters. No relatives visited during the audit. Five incident forms evidenced family members had been notified. The clinical manager and enrolled nurse confirmed that family are kept informed. Resident meetings occur monthly and there is documented discussion around all services provided. There are separate family meetings held six monthly that have recommenced post Covid-19 restrictions. There are monthly Reevedon Rest home family newsletters.

communication.		
<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>Reevedon Rest home provides rest home level care for up to 42 residents. At the time of the audit there were 34 residents at the facility including two younger persons and one for respite care. Thirty-one residents were under the age-related residential care (ARRC) contract.</p> <p>A mission statement, values and philosophy have been developed for the service. There is a combined Reevedon Rest home /Levin War Veterans Home business plan that has been reviewed annually. The business plan includes the vision and purpose for Enliven care. Quality goals are reviewed quarterly and include specific goals for Reevedon Home such as reduction of falls and urinary tract infections. Some goals such as the walking group, outings and men's shed have been unachievable due to Covid-19 restrictions.</p> <p>The facility manager (registered nurse (RN) with current practicing certificate) over two sites (Levin and Reevedon) has been in the role for three months. She was previously in an acting clinical nurse manager (CNM) role for PSC and has experience in clinical management. The facility manager has completed the specific orientation package and attends the quarterly managers meetings and district health board (DHB) forums. She has attended a one-day course at the DHB on quality systems. Notification of change in facility manager has been completed. The facility manager was on leave at the time of audit. The facility manager is supported by clinical nurse managers at each facility. The clinical nurse manager at Reevedon rest home has been in the role four years with previous clinical management experience. She is supported by two part-time RNs and a fulltime enrolled nurse (EN) Monday to Friday. The team is also supported by a PSC nurse consultant.</p> <p>The clinical nurse manager has maintained over eight hours annually of professional development including a PSC study day, group training three times a year and zoom meetings.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Presbyterian Support Central has a quality management system in place that includes internal benchmarking with the other PSC sites. There is an annual meeting schedule including combined (both homes) senior team meetings, staff meetings including infection control, clinical/RN/EN meetings and quarterly health and safety committee meetings. The senior team meeting acts as the quality committee and reviews progress with the quality programme/goals and reviews and monitors quality improvements, accident/incident reports. Topics relating to internal audits and outcomes, human resource issues, health and safety, resident/relative issues, clinical/business risk, complaints, policies, restraint infection control, incident data, education/training and business plan goals are discussed. There have been additional Covid-19 meetings and debriefs during Covid-19 restrictions.</p> <p>There is an internal audit calendar in place which includes environmental, support services and clinical services audits. Re-audits had been completed for results less than expected. A summary of audit corrective action plans was maintained and signed off as completed. Monthly collation of accident/incident data and analysis is shared with staff at staff meetings and displayed in the staff office. A Corrective action/s for any incidents above the</p>

		<p>benchmarking KPIs is reported at meetings. The service has continued to remain below the PSC key performance indicator (KPI) for falls and urinary tract infections (UTIs).</p> <p>The service has policies and procedures to provide assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. All policies are reviewed by relevant personnel at head office and sent out to the facility manager who is responsible for document control within the service, ensuring staff are kept up to date with the changes.</p> <p>The 2020 survey informed an overall satisfaction with the service at Reevedon rest home for residents at 89% and relatives at 85.6%. Corrective actions were established in areas identified, followed up and completed, relating to meals and activities. The January 2021 resident/relative satisfaction survey results showed an overall resident satisfaction rate of 81%. Other results were not available at the time of the audit. The decrease in overall satisfaction could be related to Covid-19 restrictions/lockdown period.</p> <p>The service has a health and safety management system, and this includes a health and safety representative (enrolled nurse) that has completed health and safety training provided by an external consultant. The health and safety committee meet every three months and is open to staff with good attendance. The health and safety representative orientates new staff and contractors to a site induction. There is an up-to-date hazard register, which was last reviewed in December 2020. A resident/relative satisfaction survey is completed annually.</p> <p>Falls prevention initiatives are in place and include providing the best walking experience for the residents by ensuring that residents shoes were comfortable and well fitting.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service collects a set of data relating to adverse, unplanned and untoward events. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services. Five incident forms for Reevedon rest home for the month of January were reviewed. All incident forms have been fully completed and residents reviewed by a RN and signed off by the clinical nurse manager. Neurological observations were documented and completed for four un-witnessed falls with potential head injuries sampled.</p> <p>Discussions with the clinical nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. One section 31 notification was completed in July 2019 following an electrical storm that damaged phone lines and internet connections.</p>
Standard 1.2.7: Human	FA	There is a human resources policy including recruitment, selection, orientation and staff training and development.

<p>Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>The recruitment and staff selection process requires that relevant checks are completed, and these are completed at head office. A copy of qualifications and annual practising certificates including RNs, ENs, general practitioners (GP) and other registered health professionals are kept. Five staff files were reviewed (one RN, one EN, two caregivers and one kitchen hand). All staff files reviewed included the appropriate employment and recruitment documents, including annual performance appraisals.</p> <p>The service has an orientation programme in place. Care staff stated that they believed new staff were adequately orientated to the service. The completed caregiver orientation results in a level 2 Careerforce qualification. The on-site in-service education programme for 2020 has been completed and the plan for 2021 is being implemented. Eight hours of staff development or in-service education has been provided annually. PSC has in place a comprehensive three-year compulsory training programme for registered nurses, enrolled nurses, care staff and support staff to ensure all requirements are being met. External trainers include the physiotherapist for safe manual handling sessions and the pharmacist for medication education. There is a Careerforce assessor available from head office.</p> <p>There are three RNs (including the clinical nurse manager and one enrolled nurse) who have all completed interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale for determining staffing levels and skill mixes for safe service delivery. Reevedon rest home has seven days a week RN cover including a fulltime clinical nurse manager who is dedicated to Reevedon rest home. The facility manager covers both PSC sites in Levin. The clinical nurse manager and the RN share on-call duties. An enrolled nurse is on duty Monday to Friday from 7 am to 3.15 pm. There is a medication competent caregiver on each duty who is the shift leader. The roster is able to be changed in response to resident acuity.</p> <p>There are two care staff on full morning duty from 6.45 am to 3.15 pm and one care staff from 7 am to 1.30 pm. On afternoon shift there are two care staff (3-11 pm) and one from 4-9 pm). There are two care staff on night duty. Staff reported that staffing levels and the skill mix is appropriate and safe. Residents interviewed reported that they felt there was sufficient staff on duty to meet their needs.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current</p>	FA	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are safely stored in the medication room. Registered nurses, enrolled nurses and caregivers administer medicines. Medication competencies and medication education is completed annually. The RN on duty reconciles the blister packs on delivery and records this in the electronic medication system and signed on the back of the medication blister pack. There are no stock medications on site. There were no self-medicating residents on the day of audit. The medication fridge and room air temperature are monitored and recorded daily.</p>

<p>legislative requirements and safe practice guidelines.</p>		<p>Eye drops had been dated on opening. Oxygen cylinders were checked weekly.</p> <p>Ten medication charts were reviewed (nine electronic and one paper-based). All charts had photo identification and allergy status documented. There was evidence of three-monthly medication reviews by the GP for long-term residents. The RN on duty at the Levin Home is contacted after hours for authorisation of 'as required' medications. The effectiveness of 'as required' medications is recorded in the electronic medication system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals, morning and afternoon teas and sandwiches are prepared and cooked at the PSC Levin Home for War Veterans. The menu has been reviewed by a dietitian. All meals and foods are transported by van specially configured to carry hot boxes. There were sufficient breakfast food/snacks sighted in the pantry. Breakfast is served in bedrooms by care staff. There is a morning kitchen hand (8 am to 2 pm) and an afternoon kitchen hand (4-7.30 pm). Lunch and evening meals are buffet self-service in the main dining room, supporting resident choice and control. The main meal is provided at the evening meal time.</p> <p>Dietary needs are known with individual dislikes with alternative meals provided. There were no special dietary requirements on the day of audit.</p> <p>The food control plan expires 23 January 2022. All staff have been trained in food safety and hygiene. Fridge, freezer and serving temperatures are taken and recorded daily. All foods were dated and stored safely.</p> <p>Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</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>Care staff follow the care plan and report progress against the care plan each shift at handover and complete electronic progress notes. When a resident's condition changes, the RN initiates either a GP or nurse specialist consultation. If external medical advice is required, this will be initiated by the GP. Care plans are updated to include monitoring and reporting requirements for short term needs.</p> <p>Staff have access to sufficient medical supplies (eg, dressings). On the day of audit there were five residents with wounds. These included skin tears, lesions and one post-surgical wound. Wound assessment, monitoring and wound management plans were completed for all wounds. All wounds have been reviewed in appropriate timeframes. Photos demonstrated the healing process. The RNs have access to specialist nursing wound care management advice through the district nursing service. There had been district nursing involvement for the post-surgical wound.</p> <p>Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p>

		Monitoring charts include observations, food and fluid charts, bowel monitoring, weight monitoring (monthly or more frequently if required), pain monitoring, neurological observations, blood sugar levels and behaviour monitoring.
<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>	FA	<p>There are two newly employed recreation officers. One has previously worked in a dementia care unit and the other has been involved in dementia day care programme. Both are being mentored by the previous diversional therapist (DT). The recreational officers cover seven days a week between them from 9 am – 3 pm daily. PSC Reevedon rest home activities programme is elder directed and resident focused. There are 20 volunteers between the two sites involved in the programme. The programme meets the recreational needs of the residents and reflects normal patterns of life. The programme is flexible to adapt to resident outings and also includes impromptu activities.</p> <p>There are resident led activities such as bingo and card games. Volunteers coordinate newspaper reading, quizzes and inter-home bowls. Every Friday the Reevedon café is open for barista and is also open to the community. There are weekly church services, fortnightly K9 pet therapy and regular entertainers. Residents enjoy twice weekly outings to the library, beach, parks, museums and scenic drives. Residents have the opportunity to go shopping weekly.</p> <p>A resident life story and activity profile is completed on admission in consultation with the resident/family (as appropriate). The activities documentation in the resident files reviewed were tailored to reflect the specific requirements of each resident. The residents are involved in decisions that relate to themselves and to what happens in their home. Residents interviewed evidenced that the activity programme had a focus on maintaining independence and valuable social connections.</p> <p>In the files reviewed the recreational plans had been evaluated six monthly and updated where required.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files reviewed demonstrated that the long-term care plans were evaluated at least six-monthly against goals of care. Care plans were amended where there was a change in health status. There was at least a three-monthly review by the GP. All changes in health status were documented and followed up. The resident and/or relative are involved in the care plan evaluation. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>The facility has a current building warrant of fitness that expires 28 February 2022. There is lift and stair access to the eight resident rooms upstairs. There is a maintenance person (across two PSC sites) providing two days a</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>week maintenance at Reevedon rest home. He also provides on-call support 24/7. Staff complete a maintenance request in the log book for any repairs/requests which are addressed when on site or sooner if more urgent. There are planned weekly, monthly, two-monthly, three and six monthly internal and external building maintenance schedules in place that include all service areas and resident related equipment such as wheelchairs. Water temperature monitoring of selected rooms is carried out each month (sighted). The plumber addresses any issues with temperatures outside of the acceptable range.</p> <p>The gardens and grounds are well maintained and able to be accessed safely.</p> <p>Care staff interviewed, stated they have sufficient equipment to safely deliver care as outlined in the care plans, including sensor mats.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse (RN) is supported by the clinical manager who enters all infections into the online Leecare resident management system. This generates monthly reports for the service and quarterly reports are fed back from head office with benchmarking results. The information obtained through surveillance is used to determine infection control activities, resources and education needs within the facility. There has been additional infection control training and toolbox talks during Covid-19 restrictions to keep staff and residents updated. Information, resources (personal protective equipment) and regular zoom meetings were provided by the DHB.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. The GP and the service monitor the use of antibiotics. Infection control data is discussed at clinical and staff meetings including trends, analysis and any areas for improvement.</p> <p>There have been no outbreaks.</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>Reevedon rest home has restraint minimisation and safe practice policies and procedures in place that include the definition of restraint and enablers that are congruent with the definition in NZS 8134.0. There were no residents requiring restraint or enablers at the time of the audit. The service is committed to maintaining a restraint-free environment. Staff receive training in restraint minimisation and enablers, and the management of challenging behaviours.</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.

No data to display

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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Presbyterian Support Central has an Enliven quality management system in place that includes internal benchmarking with the other PSC sites. Data collated, is used to identify any areas that require improvement.</p>	<p>The clinical nurse manager completes a monthly falls trends and analysis report that identifies environmental concerns and individual resident falls risks and preventative actions. All results are discussed with staff and reports displayed. Each resident has a falls prevention plan. Residents who fall are offered a trial of hip protectors prior to purchasing their own. A perimeter mattress was put in place for one frequent faller (four falls in January) which has been successful with no falls in February or March to date. Resident footwear is part of the admission assessment and there is ongoing consultation with the resident and family to ensure the residents shoes were comfortable and well-fitting. Staff have attended falls prevention education in November 2020 and safe manual handling sessions provided by the physiotherapist. The physiotherapist is involved in the review of residents who fall. The service has continued to reduce falls over 2019 and 2020 and is 12% below the PSC KPI for falls.</p>

End of the report.