# Final Inspection Report

Presbyterian Support Services Otago Incorporated -
Ross Home and Hospital

Date of inspection: 2 December 2010



**HealthCERT**
**Provider Regulation**
**Ministry of Health**

## Contents

**File Ref:** **WPR26**

**Provider:** Presbyterian Support Services Otago Incorporated Ross Home and Hospital

**Contact Person:** **XXX XXX**

**Premise:** Ross Home and Hospital
360 North Road
Dunedin 9054

## Executive Summary

### History

The provider is currently certified for four years with a certificate due to expire September 2014. The provider is certified for hospital (medical and geriatric) and rest home services.

The 2007 certification audit resulted in three partial attainments. The 2009 surveillance audit resulted in two partial attainments. The 2010 certification audit has resulted in ten continuous improvements and two low risk partial attainments.

### Previous Recent Complaints known by the Ministry of Health

There were two complaints in 2009, both of which were unsubstantiated.

### Nature of current complaint

The Ministry of Health (the Ministry) and Southern District Health Board (DHB) received a complaint about the services provided at Presbyterian Support Services Otago Incorporated Ross Home and Hospital. If substantiated, the provider may have been in breach of its obligations under the Health and Disability Services (Safety) Act 2001.

In summary, the complaint alleged that a former resident (Mr XXX) of Presbyterian Support Services Otago Incorporated Ross Home and Hospital was taken to Dunedin Hospital and was in a poor physical state on arrival.

The key concerns communicated from the DHB were:

- care plan (out of date)
- management/ wound care of multiple pressure ulcers (photos)
- malnourishment (condition on admission)
- Medication (confusion from faxed notes)

Photos of the resident's wounds taken on the 19 November 2010 post admission to Dunedin Public Hospital were forwarded to HealthCERT.

## Service Description

Ross Home and Hospital provides Hospital (medical and geriatric) and Rest Home services. The total service capacity is 124. This inspection focused on the Lindsay Unit - a secure psychogeriatric unit.

The occupancy and capacity of the Lindsay Unit is outlined below:

| Area | Occupied | Capacity |
|---|---|---|
| Hospital -psychogeriatric unit | 23 | 24 |

## Reasons for the inspection

The purpose of the inspection was to determine whether health care services being provided by Presbyterian Support Services Otago Incorporated Ross Home and Hospital, were being provided in compliance with section 9 of the Health and Disability Services (Safety) Act 2001 (the Act), that is a person providing health care services of any kind must do so whilst meeting all relevant standards.

Health and Disability service providers are required under section 9 of the Act to provide services:

(a) *'while certified by the Director-General to provide health care services of that kind; and*

(b) *While meeting all relevant service standards;*

(c) *in compliance with any conditions subject to which the person was certified by the Director-General to provide health care services of that kind; and*

(d) *in compliance with this Act.'*

## The inspection team

The inspection was undertaken by XXX XXX, Senior Advisor, HealthCERT, under the delegated authority of the Director-General of Health, XXX XXX, South Island Shared Service Agency Limited (SISSAL) auditor and XXX XXX, Clinical Nurse Specialist Wound Care, Southern DHB.

## Methodology

The inspection was conducted to investigate the complaint made to the Ministry that may have identified systems failures and non-compliance against the Health and Disability Services Standards. Findings are according to the Health and Disability Services Standards NZS8134:2008.

The inspection was conducted using the following methods:

- Interview with Manager
- Interview with registered nurses (Clinical Leaders)
- Individual staff interviews
- Relative/ Resident interviews
- Observation: During facility tours and casual observation of the facility
- Observation: Residents and Staff
- physical head to toe examination of patients
- Document and policy review: See the appendix for a list of documents that were requested as part of the audit process.
- Clinical Notes review: A sample of residents' notes from the facility was audited.

All patients in the Lindsay unit were reassessed by Southern DHB Wound Care CNS as part of the inspection process.

In addition a random selection of twelve patients from the Dunrowan, Craig, Dalkeith and Kilgour Units (Rest Home and Hospital) were assessed by the Wound Care CNS. This assessment indicated that the standard of care received by the residents reviewed in the Dunrowan, Craig, Dalkeith and Kilgour Units was excellent. Risk assessment, planning, documentation, clinical review and equipment were of a very good standard.

## Limitations

The scope of the inspection was limited to the issues raised in the complaint. The complaint had been referred to the Health & Disability Commissioner for further investigation under Section 31.2 of the Health & Disability Commissioners Act.

## Entry Meeting

Present: XXX XXX (Ministry), XXX XXX (SISSAL), XXX XXX (Southern DHB), XXX XXX (Facility Manager), XXX XXX (Quality Manager Presbyterian Support).
A copy of the letter of introduction addressed to XXX XXX was provided.

A proposed agenda for the day was discussed included a request to interview any relatives or health professionals visiting the facility during the course of the day. The inspection commenced with a tour of the facility.

## Summary of Inspection findings

Summary of findings where non-compliance to the Health and Disability Services Standards has been identified specific to the complaint and inspection.

## Organisational Management - Standard 1.2

**1.2.3.4 – There is a documented control system to manage the policies and procedures.**

***Partial attainment***

Staff in the Lindsay Unit were only able to evidence one of three pages of the pressure ulcer risk policy in the document folder .

**Corrective Actions:**
The provider is required to ensure that the pressure ulcer prevention and management policy and guidelines is up to date, reflects current good practice and is available to staff.

**1.2.4.3 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.**

***Partial attainment***

There is evidence of incident accident reports in patient files in the 2009/2010 files.

As part of the adverse event reporting process, ulcer incidents data is collected at Ross Home and Hospital. Individual incident reports are required for each incident and the unit nurse manager (for each unit within the facility) completes the corrective actions/follow up.

The Health and Safety Committee for the facility analyses the data collected from the monthly report provided from each unit.

However, there was evidence of an incident in the progress notes of the failure of an air mattress that was not reported or recorded through the adverse event reporting process. Additionally the manager confirmed no pressure ulcers have been reported in 2010.
**Corrective Actions:**

The provider is required to ensure that staff are fully aware of the organisational requirements regarding recording and reporting adverse events.

**1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.**

***Partial attainment***

There is an in-service training programme and records of attendance are maintained.

There was evidence of a wound care education session in March 2010. The last pressure ulcer education session records evidenced for the service was February 2009.

The caregivers stated that they don't get training in pressure ulcer prevention or wound care.

They refer to registered nurse's for any issues.

The registered nurse's stated that education and training is provided for registered nurses on pressure ulcers.

One registered nurse interviewed did not know how to operate the air mattress effectively (adjust dial to patient weight). The registered nurse also stated an incorrect understanding of the use of air mattresses (i.e. that patients nursed on an airmatress don't require turning).

Care interventions described focused on applying creams to skin to alleviate dryness (which is beneficial). However, pressure relieving devices (i.e. heel boots/foam wedges) were not evidenced in use.

A number of residents were found to have very tight shoes which caused reddened toe knuckles (Grade 1 Pressure Ulcer)

**Corrective Actions:**
The provider is required to ensure that service care providers (including caregivers) receive relevant pressure ulcer prevention/care education to support safe and effective care of consumers, including inservice education or the correct use of equipment.

## Continuum of Service Delivery - Standard 1.3

**1.3.3.3 Each stage of the service provision (assessment, planning, provision, evaluation, review and exit) is provided in time frames that safely meet the needs of the consumer.**

***Partial attainment***

Files reviewed in the Lindsay Unit evidenced communication with family in the progress notes and lifestyle plans. However, Mr XXX's file identified that requests/concerns about his care from a family member and the GP locum were not addressed in a timely fashion. Further a request from the locum GP on 5/11/10 to get the nurse wound care specialist involved when the wound was noted as necrotic and from Mrs XXX on 9/11/10, were not actioned until 16/11/10.

Information viewed on Mr XXX's file identified that Mr XXX's regular GP noted the pressure wounds at a number of visits between June and October 2010. There was no evidence on file of a full physical reassessment by the GP or documented objective information about the size and number of wounds between June 2010 and October 2010. There is no evidence of specialist referrals being made by the regular GP regarding pressure areas.

There was documented evidence of Presbyterian Support dietician input. Mr XXX was prescribed the nutritional supplement, fortisip.

**Corrective Actions:**

The provider is required to ensure that:

1. Service provision timelines are documented in accordance with policy, good practice guidelines, contracts and the Health and Disability Services Standards.
2. All consumers are assessed to ensure appropriate care and outcomes.
3. Assessments are accurately documented, linked to the plan of care and evaluated to safely meet the needs of the consumer.

**1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.**

***Partial attainment***

The Presbyterian Support policy in relation to multidisciplinary clinical reviews requires that these are carried out every three months. However five of ten files reviewed did not have three monthly clinical reviews in accordance with stated policy. The family and/or GP were not evidenced as being involved in reviews in the majority of the files reviewed.

**Corrective Actions:**

The provider is required to ensure that:

1. multidisciplinary services reviews are carried out for all residents three monthly and as clinically indicated
2. there is documented evidence of appropriate multidisciplinary team and family member involvement in relation to these reviews.

**1.3.4.1 Service providers seek appropriate information and access a range of resources to enable effective assessment.**

***Partial attainment***

There is a pressure risk assessment tool used at the facility. However, Presbyterian Support Otago pressure risk assessment procedures were not implemented in accordance with policy in the Lindsay Unit.

**Corrective Actions:**

The provider is required to ensure that:

Staff seek appropriate information and are able to access appropriate resources to enable effective assessment of pressure ulcer risk/areas. Specifically, residents must be re-examined according to their level of risk and change of condition i.e. those with medium risk of pressure ulcers must be assessed at least weekly and with high risk assessed daily. Decisions on best pressure relieving practice should be made within the multidisciplinary team meeting and this process needs to be documented and communicated to staff. Staff should then apply these appropriately during ongoing patient care.

**1.3.4.4 Assessment and intervention outcomes are communicated to the consumer, referrers, and relevant service providers.**

***Partial attainment***

Assessments and interventions are not completed or communicated accurately to consumers/ family, referrers, all relevant staff and and relevant service providers as evidenced through Mr XXX's file review and the clinical reviews.

All 23 residents in the Lindsay Unit were reassessed by clinical nurse managers from other wards within Presbyterian Support Ross Home and Hospital, prior to the joint Ministry and DHB inspection audit, as part of Presbyterian Support's internal review process in response to the concerns raised about Mr XXX's care. A gap analysis/risk assessment tool specially developed for this purpose by the Presbyterian Support Quality Coordinator was used.

On 2 December 2010 eight of those gap analysis/risk assessment records were reviewed and five residents were re-examined by the DHB Wound CNS. On 6 and 7 December the remaining 19 residents in the Lindsay Unit were reassessed by the Wound CNS.

The Clinical assessments carried out as part of the inspection were reasonably consistent with those of the internal review findings, with the exception of the identification of a number of additional low grade wound/pressure areas.

The Presbyterian Support internal investigation highlighted a number of potentially serious short comings in assessment, planning, documentation and re-evaluation of each resident particularly in regard to pressure risk assessment and wound care. These were confirmed by the external inspection process.

**Corrective Actions:**

The provider is required to ensure that:

1. They are able to provide evidence that the issues highlighted in the risk assessments are followed up on immediately and appropriate interventions are implemented
2. Issues identified through residents assessments are communicated to all relevant staff, referrers and family and this communication is documented.

**1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process**

***Partial attainment***

The internal risk assessments completed on the 23 Lindsay Unit residents by the clinical nurse managers from other wards within Presbyterian Support Ross Home and Hospital and the external reassessment completed as part of the inspection process of the same residents, along with Mr XXX's file review highlighted a number of potentially serious short comings in the evaluation and care planning of residents in the Lindsay Unit.

**Corrective Actions:**

The provider is required to ensure that:

Documented short and long term care plans for all residents in the Lindsay Unit are goal orientated, reflect the ongoing assessment and detail the support and interventions needed to achieve the desired outcomes.

**1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes**

***Partial attainment***

Mr XXX's file and the 23 resident reassessments evidenced that the assessment and care plans documented did not reflect the level of need/risk and intervention required.

Personal cares/skin cares are part of the caregivers daily work. Caregivers stated that if they have concerns about a residents skin status i.e. reddened area, they would ask the registered nurse on duty for advice. They would also document their concern.

There was no documented evidence of a turning schedule, although staff said that patients do get turned regularly up to every 2 hours

**Corrective Actions:**

The provider is required to ensure that:

1. Interventions are appropriate to the assessed need/risk.
2. Required interventions are accurately communicated (staff shift handovers, Multidisciplinary team meetings, family) and documented, for all service providers to follow.

**1.3.8.1 Evaluations are conducted at a frequency that enables regular monitoring of progress towards achievement of desired outcomes.**

***Partial attainment***

Clinical Multidisciplinary team reviews were not conducted according to the policy in 5 of 10 files reviewed.

Presbyterian Support Otago pressure risk assessment procedures were not implemented in accordance with policy in the Lindsay Unit.

**Corrective Actions:**

The provider is required to ensure that:

Evaluations are completed according to policy and as necessary to meet desired clinical outcomes and good practice guidelines.

**1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.**

***Partial attainment***

Five of 10 files reviewed did not have up to date clinical reviews as per policy. The family and GP were not evidenced as being involved in most clinical reviews.

**Corrective Actions:**

The provider is required to ensure that:

All care plans are evaluated, to reflect the degree of progress toward desired outcomes.

**1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.**

***Partial attainment***

Changes in residents progress were not accurately reflected in the care plans (evidenced in clinical review of residents by clinical nurse managers from other wards within Presbyterian Support Ross Home and Hospital and the Ministry and DHB re audit of residents)

**Corrective Actions:**

The provider is required to ensure that:

When consumer progress does not reflect the care plan goals and outcomes reassessment, evaluation and appropriate referral occurs.

## Safe and Appropriate Environment - Standard 1.4

**1.4.2.3 Amenities, fixtures, equipment, and furniture are selected, located, installed, and maintained with consideration of consumer and service provider safety, needs, and abilities.**

***Partial attainment***

- Staff were unable to locate a heel boot to relieve pressure for heels. Although they all stated that they are available.
- Foam blocks or foam wedges for positioning residents were not able to be located.
- Several old spenco mattresses were scattered in rooms. Four staff reported they are used on the floor to protect residents from harm when falling.
- Air mattresses (pump at the end of bed) are available. Two were checked and it was found that the tubing was loose and could become easily dislodged rendering the pump useless. One registered nurse could not demonstrate how to adjust the air mattress dial to patient weight and also incorrectly said that patients on air mattresses don't need to be turned.
- Two (one assessed as medium and the other as high pressure ulcer) residents were observed lying in same position in a lazy-boy chair in the lounge for an extended period of time.
- Care givers moving a patient from chair to bed didn't know how to use the manual handling equipment.
- Minimal use of equipment to transfer residents from chair to standing resulting in bruising, pulling on arms and shoulders.
- No evidence of use of equipment to prevent friction e.g. sliding sheets despite a number of residents having grazes.

**Corrective Actions:**

The provider is required to ensure that:

1. All pressure relieving equipment is reviewed immediately and that routine checks and maintenance are carried out.
2. Staff are educated on the use of all equipment.
3. Appropriate equipment is provided and used according to the assessed need of the residents.
4. Equipment type and use is specified in sufficient detail in the care plan to guide staff.

## Summation meeting

A summation meeting was attended by

XXX XXX (Ministry), XXX XXX (SISSAL), XXX XXX, (Southern DHB), XXX XXX (Facility Manager), XXX XXX (Quality Manager Presbyterian Support).

XXX XXX thanked the facility for their participation and approach to the investigation recognising that this was an unannounced inspection. It was explained that a full summation of findings could not be provided at the closing meeting as information gathered needed further analysis. XXX XXX noted that one relative interview was completed and that the relative had been complimentary about the service, noting that staff were approachable.

XXX XXX confirmed that there would be findings against the Health and Disability Services Standards and these would be likely to include the following areas:

Assessments – risk assessments/ care plans – lack of documentation / evidence of effective interventions - substantiated

Pressure Ulcer Policy being implemented and know by all staff – full policy not available on ward - substantiated

Equipment – faulty equipment, knowledge and availability of equipment - substantiated

Adverse event reporting – air mattress failure not reported through adverse event process / no pressure ulcers reported to management this year- substantiated

**Key issues raised at summation were:**

The need for the provider to address the concerns identified from the reassessments of 23 residents in the Lindsay unit immediately.

The provider communicated a willingness to work proactively on the improvements required and to work with the DHB to ensure actions reflected good practice.

The DHB undertook to provide clinical oversight and support.

## Conclusion

Presbyterian Support Services Otago Incorporated Ross Home and Hospital is required to take corrective actions, as identified, to improve compliance against the Health and Disability Services Standards. On-going monitoring will be undertaken by the Southern District Health Board in conjunction with the Ministry of Health.

The complaint about the clinical management of services provided by Presbyterian Support Services Otago Incorporated Ross Home and Hospital, which alleged that care plan documentation was out of date and management/wound care was not appropriate was substantiated.

A written progress report from Presbyterian Support Services Otago Incorporated Ross Home and Hospital outlining the corrective actions taken following the inspection up to 13 December 2010 is attached as appendix one.

## Additional Conditions

Additional conditions to be placed on the Certification Schedule:

1. A written progress report that outlines all actions undertaken by the Provider in relation to Health and Disability Services Standards: 1.2.3.4, 1.2.4.3, 1.2.7.5, 1.3.3.3, 1.3.3.4, 1.3.4.1, 1.3.4.4, 1.3.5.2, 1.3.6.1, 1.3.8.1, 1.3.8.2, 1.3.8.3 and 1.4.2.3 as identified in the Inspection Report must be submitted to your District Health Board by 6 January 2011. Your District Health Board will notify the Director-General of Health of progress, if any, if required in accordance with the Ministry of Health's requirements for the processing of progress reports.
2. A surveillance audit of the provider must be undertaken by a designated auditing agency by 2 May 2011. The audit report will be forwarded to the Director-General of Health.

## Summary for Publication

The Ministry of Health received information about a complaint from the Southern District Health Board about the care provided to a resident at Presbyterian Support Services Otago Incorporated Ross Home and Hospital – Lindsay Unit.

In summary, the complaint alleged that a resident did not receive appropriate care.

The purpose of the unannounced inspection undertaken on 2 December 2010, was to determine whether health care services being provided by, Presbyterian Support Services Otago Incorporated Ross Home and Hospital were being provided in compliance with section 9, of the Health and Disability Services (Safety) Act 2001. That is a person providing health care services of any kind must do so whilst meeting all relevant standards

Corrective actions are required for the findings identified specific to the complaint and inspection in the following areas:

*Organisational Management*:
The organisation must ensure that the pressure ulcer prevention and management policy and guidelines are up to date, reflects current good practice and are available to staff. All care providers must receive relevant pressure ulcer prevention/care education to support safe and effective care of consumers. In addition care providers are required to be fully aware of the organisational requirements regarding recording and reporting adverse events.

*Continuum of Service Delivery:*
Service provision timelines must be documented (in accordance with policy, good practice guidelines, contracts, Health and Disability Services Standards). All consumers must be assessed and these assessments accurately documented and linked to the plan of care which is evaluated to safely meet the needs of the consumer. Issues identified through residents assessments must be communicated to all relevant staff, referrers and family and this communication must be documented. Interventions must be appropriate to the assessed needs and accurately communicated and documented, for all service providers to follow. Care evaluation must be completed in accordance with policy and as necessary to meet desired clinical outcomes and good practice guidelines.

*Safe and Appropriate Environment:*
The pressure relieving equipment must reviewed and routine checks and maintenance carried out. Presbyterian Support Services Otago Incorporated Ross Home and Hospital must ensure that appropriate equipment is available and used in accordance with assessed

need. Staff should be educated in the use of all pressure relieving equipment. Equipment type and use must be specified in sufficient detail in the care plan to guide staff.

Presbyterian Support Services Otago Incorporated Ross Home and Hospital is required to complete the required corrective actions by 6 January 2011. Ongoing monitoring will be undertaken by the District Health Board in conjunction with the Ministry of Health.

## Appendix 1: Presbyterian Support Services Otago Incorporated Ross Home and Hospital – Summary of Actions to 13 December 2010

Requirements as identified by external auditors on 2, 6 and 7 December 2010.

Progress report Monday 13 December 2010.

Detailed below is a summary of the requirements set out to us at feed back meetings on 2, 6 and 7 Dec. I have summarized progress thus far against these.

Our current focus (today, tomorrow and Wednesday) is on getting all aspects of support plans up to date and reflecting appropriately information from all assessments/reviews. Many of these were already in place at the time of external audit. However, we are rewriting them all. PSO has a well tested system/process and documents for assessment, intervention and evaluation/review. We are working at this time to get this implemented to a very high level of performance in Lindsay unit such that it exceeds minimum standards as is the case in all other 4 units at Ross Home. There are a number of very experienced staff working on this including the Unit Nurse Managers from our other units and an experienced registered nurse with support from myself.

1. Need to get in place for all high risk residents appropriate pressure relieving equipment and pressure relieving interventions **immediately**.
   **Progress:** Appropriate mattresses and seating has been put in place (by lunchtime 8 Dec) with appropriate input from our physiotherapist.

2. Need to get in place for all high risk residents pressure risk assessments, support plans (re skin integrity) and related documentation including wound charts **immediately.**
   **Progress:** For high risk residents, pressure risk assessments, support plans (skin integrity) and wound charts were put in place last week (by lunchtime 8 Dec).

3. Need to get in place for all medium risk residents appropriate pressure relieving equipment and pressure relieving interventions **within 48 hours**.
   **Progress:** Appropriate mattresses and seating has been put in place (by Friday afternoon – 9 Dec) with appropriate input from our physiotherapist.

4. Need to get in place for all medium risk residents pressure risk assessments, support plans (re skin integrity) and related documentation including wound charts **within 48 hours.**
   **Progress:** Appropriate mattresses and seating has been put in place (by Friday afternoon – 9 Dec) with appropriate input from our physiotherapist.

5. Need to address breakdowns in communication with family and enable their involvement.
   **Progress:** Families were informed by letter that some issues had arisen and were currently being addressed (letter sent week ago Saturday). Families were addressed before Xmas party last Weds that there had been some issues that were being addressed and that all residents will have a clinical review before Christmas and that a relatives meeting would take place this Thursday).

   All residents will have had a full multidisciplinary review with the opportunity for family to be fully involved before Christmas. That review programme began after the external audit on 2 Dec.
   All staff have been reminded that families must be notified of all incidents and changes in health status.

6. Review policy on frequency of pressure risk assessment.
**Progress:** At this point, the frequency of scoring pressure risk is the same as DPH. However, we are using the PSO risk assessment tool and recording in a different way to DPH. The PSO risk tool actually gives residents a higher risk score than Braden so if anything the risk is overstated. We feel it appropriate to stay with PSO tool for now given that gives a higher rather than lower score. We will complete a more detailed review in due course and move to Braden once the immediate actions are completed.

7. Review policy on frequency of pressure relieving interventions especially turning/changing position. (Note that lazy boy chairs are not pressure relieving. Use flotation chairs where necessary.) Currently, there is a heavy focus on creams and lotions which is useful but not on pressure relieving interventions.
**Progress:** PSO policy already includes appropriate pressure relieving interventions that are linked to the risk level. These interventions are now fully documented in skin integrity support plans and have been discussed with staff. A repositioning chart has been put in place for all high risk residents.

The physiotherapist has reviewed all seating (last week) and appropriate equipment and seating is in place for all residents.

8. Review of pressure relieving equipment (including mattresses and heel relief).
**Progress:** This has been reviewed as detailed in sections above.
Pressure relieving equipment for heels has always been available. Its availability and use has been discussed with staff.

Ensure registered nurses know how to access pressure relieving equipment.
**Progress:** Equipment has always been available. How to access pressure relieving equipment hs been discussed with staff.

9. Review maintenance programme for pressure relieving equipment.
**Progress :** A maintenance schedule has been in place for many years. It will be reviewed in due course to address the shortfalls that have occurred in Lindsay unit.

10. Implementation of incident reporting policy in Lindsay unit. [Includes; reporting pressure damage and equipment failure; informing families of incidents; taking appropriate action after incidents; following up that actions have been taken.
**Progress:** Incident reporting process is well developed and established across PSO. It has not been implemented as it should be in Lindsay. This has been addressed by the Acting Unit Nurse Manager who is well experienced in the process and has a lead role in health and safety at Ross Home.

11. Address the breakdown in "team" in Lindsay unit. Other members of the MDT and carers need to be involved in review.
**Progress:** There will be many actions in due course to address this. In the short term, an Acting Unit Nurse Manager is in place with support from experienced staff. The current round of clinical reviews is certainly including input from the MDT and carers.

12. Ensure timely referral for reassessment of residents takes place if there category of care (D6 vs hospital) changes.
**Progress:** The reassessment process is well established. However, it appears not to have been implemented in as timely fashion as it could be in Lindsay unit. This will not be the case with an Acting Unit Nurse Manager in places who has a proven track record in ultilising reassessment appropriately.

**Please note that this progress report is not exhaustive. It provides a summary of some of the main actions we have already taken and are in the process of taking at the current time.**

**Prepared by XXX XXX, Quality Manager on behalf of XXX XXX Manager and PSO.**

**18.00 on 13 December 2010.**

## Appendix 2: Documents requested

- Training records
- Resident files
- Policies