

# St Patrick's Home and Hospital Limited

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## Introduction

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

The audit has been conducted by Health Audit (NZ) 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:

<b>Legal entity:</b>	St Patrick's Home and Hospital Limited
<b>Premises audited:</b>	St Patrick's Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 4 December 2014      End date: 4 December 2014
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	43

# Executive summary of the audit

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## 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

The surveillance audit was undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board contract. St Patrick's Home and Hospital provides residential hospital and rest home level care for up to 60 residents with 43 residents occupying the service on the day of the audit.

Evidence was gathered through interviews, review of documentation and observation.

There are two directors who provide oversight of the service and a clinical manager and assistant manager who provide operational management. Staffing was appropriate to support the needs of residents. There is a quality and risk management programme documented.

Ten improvements required at the last certification and partial provisional audits around essential notifications, staffing, assessment and care planning, verification of trades people, policies, medications, bedrooms and infection control have been addressed.

Eleven improvements are required to the following: quality and risk management, human resources issues, evaluation of care plans, storage of chemicals and infection control.

## 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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Staff were able to demonstrate an understanding of residents' rights and obligations. This knowledge was incorporated into their daily work duties and caring for the residents. Information regarding complaints and how to lodge a complaint is available to residents and their family and complaints were investigated. Staff communicated with residents and family members following an incident.

## 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 medium or high risk and/or unattained and of low risk.
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A quality and risk management programme was documented that included potential review of incidents, accidents, complaints, health and safety and an implemented internal audit schedule.

Staffing levels were adequate and interviews with residents and relatives demonstrated that they have adequate access to staff to support residents when needed.

The improvements required at the last certification and partial provisional audits around essential notifications and staffing, have been addressed. Improvements are required to the quality and risk management system, to the staffing policy and to staff files.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The residents receive safe and appropriate services in order to meet the assessed needs and desired outcome/goals of residents at rest home or hospital level of care. Each stage of assessment, planning, provision and evaluation of care is undertaken by suitably qualified and/or experienced staff who are competent to perform the function. The previous audit identified areas for improvement in the assessment of residents after a fall and ensuring the care plan reflects the changed needs of the resident. These areas are implemented and embedded into practice. There are new areas of improvement required in the time frames of the documentation of care plan evaluations and ensuring the staff respond to changes in residents needs in a timely manner.

The activities are planned to meet the needs and strengths of the residents. The activities are appropriate to the resident's needs and culture.

Food, fluid, and nutritional needs of the residents are provided in line with recognised nutritional guidelines.

Staff who are responsible for medicine management are assessed as competent to perform the role. The previous audits identified that improvements were required in the signing of medication charts and ensuring the bulk stored medications are not used for residents in the rest home. The service has implemented processes to address these previous issues.

## 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.		Some standards applicable to this service partially attained and of low risk.
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There was a current building warrant of fitness in place. There is a planned and reactive maintenance programme in place with issues addressed as these arise. Residents and family described the environment as meeting their needs.

Improvements required at the last certification and partial provisional audits around verification of trades people, documentation of a transport policy and to privacy for residents sharing a bedroom have been addressed.

An improvement is required to storage of chemicals.

## 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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The service has no restraint or enabler use. The definition of enablers reflects that these are voluntary and the least restrictive option to maintain resident safety and comfort.

## Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The service has a documented infection control programme that meets the size of the service and the needs of the residents. The service collects data on infections monthly and supplies this data for external benchmarking three monthly. Although infection surveillance data is collected and collated, there is no documented evidence that the results are trended or actions are implemented to reduce infections.

## 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)
<b>Standards</b>	0	16	0	5	1	0	0
<b>Criteria</b>	0	37	0	7	3	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisation's complaints policy and procedures is in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and includes time-frames for responding to a complaint. Complaint forms are available at the service.</p> <p>A complaints register is in place electronically and the register includes the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaint's folder.</p> <p>One complaint lodged in 2014 forwarded via the District Health Board was selected for review. The District Health Board has responded with actions to be completed. There is an action plan documented however this does not relate to the issues raised in the District Health Board letter (refer 1.2.3.8).</p> <p>Residents and family interviewed state that they would complain if they had to.</p>
<p>Standard 1.1.9: Communication</p>	FA	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available.</p> <p>Family are informed if the resident has an incident, accident, has a change in health or a change in needs as evidenced in 10 of 10 completed accident/incident forms and in the resident files.</p> <p>Family contact is recorded in residents' files – sighted in five of five resident files reviewed (three rest home and two hospital).</p> <p>Interviews with five family members (four hospital and one rest home) confirm they are kept informed. Family confirm they are invited at least annually to the care planning meetings and sign the care plan indicating they have been informed and had input. Family interviewed confirm that they are invited to attend the resident meetings which are held monthly.</p> <p>Interpreter services are available when required from the District Health Board. There are no residents currently requiring interpreting services and all residents interviewed (four rest home and one in the hospital) confirm that staff are approachable and communicate well.</p> <p>The information pack is available in large print and advised that this can be read to residents.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The mission, vision and goals of the facility are displayed in the foyer at the main entrance, included in the welcome pack for new admissions and in the facility web site. The mission, vision and goals are displayed.</p> <p>Two directors provide oversight of the service. One takes responsibility for the financial and building component of the service and the other for oversight of care and resident requirements. Both have worked in the health service industry in the past. Operational management is delegated to the clinical manager and assistant manager.</p> <p>The clinical manager is a registered nurse with a current practising certificate in New Zealand. The clinical manager worked in aged care for over seven years and has undertaken post graduate education relevant to resident care and management. The clinical manager is supported by the assistant manager.</p> <p>The service provides rest home and hospital level care for a maximum of 60 residents with an occupancy of 43 residents on the day of the audit (23 rest home and 20 hospital residents).</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>	<p>PA Moderate</p>	<p>The managers stated that there is a business and quality plan however this was not able to be sighted during the audit.</p> <p>There are policies and procedures that identify quality outcomes for key components of service delivery, including quality and risk management. These have been reviewed in 2014 to ensure they are relevant and updated where necessary. The assistant manager ensures that the current version is available staff for staff reference in the nurses office.</p> <p>The service has a documented quality programme. Staff are expected to document incidents, infections, hazards, audits, complaints and restraint if used and the data is submitted to the clinical manager for review. The clinical and assistant managers collate the data with some data not included in registers reviewed. .</p> <p>There are monthly registered nurse, health and safety, staff and resident meetings. Minutes are documented. Management meetings are held when issues arise. These are verbal and minutes are not documented. Some aspects of the quality and risk management programme is discussed.</p> <p>There is an implemented internal audit schedule. Records indicate that internal audits are completed as scheduled and corrective action plans are documented when issues are noted. Evidence of resolution against the corrective action plan is not documented.</p> <p>The service is expected to complete annual satisfaction surveys with the last survey completed in March 2013 and in October 2014. The surveys are not collated.</p> <p>Data is sent to an external company for benchmarking. Reports are sent back with generalised information from the company. Trends are not analysed by the service.</p> <p>Improvements are required to the following: plans for the service, documentation of data on registers, documentation of minutes for the management/director meetings, evidence of discussion of data including discussion of clinical issues/best practice etc, corrective action planning, satisfaction surveys, trend analysis and discussion of risks with strategies implemented to improve service delivery.</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</p>	<p>FA</p>	<p>The clinical and assistant managers are aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There are no times since the last audit when authorities have had to be notified. There have been no outbreaks since the last audit. The improvement required at the last</p>

<p>family/whānau of choice in an open manner.</p>		<p>audit has been met.</p> <p>Managers encourage staff to recognise and report errors or mistakes.</p> <p>Staff receive education at orientation on the incident and accident reporting process. Staff interviewed understand the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>Ten incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>All registered nurses and the clinical manager hold current annual practising certificates. Visiting practitioner's practising certificates include the general practitioner, dietitian, podiatrist and physiotherapist and these are current.</p> <p>Seven staff files include a signed contract, job descriptions in three files, reference checks in two files. There is an annual appraisal process in place with all staff having a current performance appraisal.</p> <p>First aid certificates are held in staff file along with other training records.</p> <p>Police checks and reference checks were not documented in files reviewed. A letter of offer and applications for the roles are at time documented.</p> <p>Staff describe an orientation programme with these evidenced in one file reviewed. Caregivers are paired with a senior caregiver for shifts prior to working on their own.</p> <p>There is an annual training plan that is implemented. Attendance records are documented at the time of the training and individual staff logs kept. The physiotherapist assistant and caregiver interviewed state that they value the training. Education and training hours exceeds eight hours a year for all staff reviewed.</p> <p>Improvements are required to ensuring that police checks, reference checks, letter of offer, application form and orientation checklists.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or</p>	<p>PA Low</p>	<p>The staffing policy is the foundation for work force planning. The staffing policy was updated to reflect a capacity of 60 residents however this requires further review.</p> <p>Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy</p>

<p>experienced service providers.</p>		<p>with a registered nurse on site at all times.</p> <p>Staff are allocated to wings and units with the clinical manager and assistant manager on five days a week. The clinical manager is on call after hours with another registered nurse available when the clinical manager is on leave.</p> <p>Residents and families interviewed confirm staffing is adequate to meet the residents' needs.</p> <p>There are currently 42 staff including the clinical manager (registered nurse), assistant manager, four registered nurses including the manager/clinical manager, one enrolled nurse and 21 caregivers. A review of the rosters indicates that staff were replaced when on leave.</p> <p>Staff required to be employed prior to opening new beds at the previous audit have been employed relevant to the number of residents currently in the service. The improvement required at the last audit has been met.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The previous audit identified an area for improvement in medicine management related to the use of bulk supply medicines in the rest home and the signing of medicine charts. These are now addressed.</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. Medicines for residents are received from the pharmacy in a pre-packed sachet delivery system or in their original containers when medications cannot be pre-packed. The bulk supply of medications is only used for the hospital residents. The pre-packed sachets and other medications are delivered by the pharmacy fortnightly. On delivery of the new sachets, these are checked for accuracy against the medicine chart/prescription.</p> <p>The medicine prescriptions/medicine charts sighted contains the required level of detail to comply with legislation and guidelines. All medicine charts sighted are reviewed by the GP in the last three months. There is a signature specimen register for the staff who administer medicines.</p> <p>Medicines, including controlled drugs, are securely stored. The temperature of the medicine fridge is recorded daily. The temperatures recorded are within safe medicine storage guidelines. The controlled drugs are signed out by two staff at each</p>

		<p>administration. There is a weekly stock count recorded in red pen in the controlled drug register. There is a six monthly stock check of the controlled drugs.</p> <p>There are documented competencies sighted for the staff designated as responsible for medicine management. The RNs and some senior caregivers are assessed as competent to perform medicine management.</p> <p>The service has processes for assessing competence of residents who wish to self-administer their medicine.</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>	FA	<p>There is a four week rotational menu with summer/winter variances, which is reviewed by a dietitian as suitable for the older person living in long term care. Every resident has a nutritional assessment review on entry to the service (and reviewed when indicated) and all residents are routinely weighed at least monthly. Residents with additional or modified nutritional needs or specific diets have these needs met. The menu clearly records the choices for residents on modified diets. The residents and family report satisfaction with the food and fluids provided.</p> <p>There is an ongoing cleaning programme in place for the kitchen and all aspects of food procurement, production, preparation, transportation, delivery and disposal are complied with to meet current legislation and guidelines. When food is decanted from its original packaging, the food is stored in food safe containers, labelled and dated. Any food that is returned to the fridge is covered, labelled and dated. Kitchen staff have completed food safety qualifications and receive ongoing education related to their role. The cook demonstrated knowledge of the residents requirements and food safety.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The previous audits identified that the incidents had no evidence of neurological observations being completed following unwitnessed falls. This is now addressed and sighted on the records for residents who have had unwitnessed falls. The nursing staff demonstrate knowledge of the process and assessment of residents who have an unwitnessed fall.</p> <p>The needs, outcomes, and/or goals of residents are identified through the assessment process and are documented to serve as the basis for service delivery planning. The service us a combination of the interRAI and the services own paper based assessments. Additional assessment tools for skin integrity/pressure area risk,</p>

		falls risk, continence assessment and nutritional assessment are evidenced in the residents' files. The assessments and care planning is based on the residents' preferences and ways that they wish to be cared for.
<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>	FA	<p>The provision of services and interventions are consistent with, and contribute to, meeting the residents' assessed needs, and desired outcomes. The care plans reviewed confirm care planning is individualised and personalised to the resident's assessed needs. Short term care plans are used where there is a specialised need (eg, falls minimisation and end of life care). The caregivers confirm they use documented interventions to provide appropriate care for each resident. The residents and families interviewed confirm they are overall satisfied with care and interventions provided by the service (also refer to 1.3.3.3).</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the resident. The group and individual activities are based on what the resident wants to do, with a strong emphasis on community activities and outings that reflect the interests of the residents.</p> <p>The residents' files reviewed have activities and social assessments. The goals are updated and evaluated in each resident's file six monthly. The activities cover cognitive, physical and social needs. The activities are modified to suit the individual needs and capabilities of each resident. Residents are also observed to be engaging in independent activities, such as going out into the community, reading, listening to music and walking in the courtyard. The residents interviewed express satisfaction with the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Where progress is different from expected, the service responds by initiating changes to the long term care plan or by the use of short term care plans. The short term care plans document that the interventions are analysed, reviewed, discussed with the resident and family and evaluated for achievement in reaching desired outcomes. Though these changes are documented in the residents file, also refer to 1.3.3.3 regarding the two family comments about their concerns about not identifying changes unless 'prompted' by the family.</p>

		<p>The care plan evaluations reviewed are resident-focused, indicate the degree of achievement or response to the support and/or intervention and progress towards meeting the desired outcome. Refer to 1.3.3.3 to ensure the evaluations are documented at least six monthly. The residents' files reviewed record that multidisciplinary team meetings, which include family consultation, are conducted at least annually.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place. The incident reporting system would be used if there are any complaints around waste management. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage.</p> <p>Information around chemicals used is located in the laundry. The hazard register is current. Staff can describe safe and appropriate handling of waste and hazardous substances.</p> <p>All staff are required to complete training regarding the management of waste during induction and through ongoing infection control training last held in 2014.</p> <p>Visual inspection of the facilities provides evidence that any chemicals are correctly labelled, and the container is appropriate for the contents including container type, strength and type of lid/opening.</p> <p>There is a locked cupboard in the hallway for chemicals.</p> <p>Trades people have had their credentials checked and these are now on file. The improvement required at the last audit has been met.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 25 September 2015). There have been no building modifications since the last audit.</p> <p>There is a planned maintenance schedule.</p> <p>The lounge areas are designed so that space and seating arrangements provide for individual and group activities with the activity programme offered in the lounges on the day of the audit. The areas are suitable for residents with mobility aids.</p>

		The following equipment is available, pressure relieving mattresses, shower chairs, hoists and sensor alarm mats. There is a test and tag programme and this is up to date (last completed September 2014) with BV Medical also completing a check of equipment in September 2014.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms.</p> <p>Equipment is sighted in rooms requiring this with sufficient space for both the equipment.</p> <p>Rooms can be personalized with furnishings, photos and other personal adornments.</p> <p>There are shared rooms and these now have curtain rails/curtains available should the residents chose to use these. The improvement required at the last audit has been met.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	PA Low	<p>Trolleys containing chemicals are kept at the top of the stairs accessed by staff, family and residents and in a room that was unlocked on the day of the audit in the main building.</p> <p>An improvement is required to ensuring that chemicals are kept safe at all times.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>An emergency policy and emergency plan is sighted that includes disaster awareness, robbery, bomb threat, hazards and threats, earthquake, tsunami, volcanic eruptions, storms, water damage, flooding, power failure.</p> <p>Emergency training is conducted during orientation. Induction includes health and safety, hazardous substances, call bell system and emergency planning including an orientation to the emergency procedures. There is evidence in training records that fire and evacuation training has been provided twice in the last 12 months.</p> <p>The transport policy has been documented and includes escort requirements. The improvement required at the last audit has been met.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The previous audit identified an area for improvement at 3.1.3 that the infection prevention and control programme had not been reviewed to include the increase in size and capacity of the service. This is now addressed. The clinical manager reports the infection control programme is sufficient to meet the needs of the residents. The infection control programme is reviewed within the last 12 months, which includes the increase capacity of the service.</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>PA Low</p>	<p>The type of surveillance at the service is determined by an external infection control benchmarking organisation. The service uses the standardised definitions from this company to determine infections. The service submits the infection data for three monthly benchmarking. The infection surveillance programme is suitable to the rest home and hospital services provided at St Patricks.</p> <p>The services surveillance data from January to May 2014 records the number of urinary tract infections and compares the results for the rest home and hospital. There is no other analysis of this data. Refer to 3.5.7. and 1.2.3.6 for inconsistency in the recorded data.</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>The previous area for improvement to ensure the restraint coordinator has a job description is now addressed. The job description was sighted and the restraint coordinator demonstrates knowledge of their role as the restraint coordinator. The restraint minimisation policy has a definition of enablers that complies with the standards. The policy records that when enablers are used, these shall be voluntary and the least restrictive option to meet the needs of the resident with the intention of promoting or maintaining consumer independence and safety. After review of the restraint/enabler register it is determined that the facility does not use any restraints or enablers. Though the restraint register records there are seven residents with a mobility bed loop/handle bar or a monkey bar, these would be considered a mobility aid and are not a type of restraint or enabler as they do not restrict the resident's movement. It is suggested that the facility review their enabler register to ensure that what they have defined as an enabler meets the organisational policy.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>Data is collected from internal audits, satisfaction surveys, infection surveillance data, complaints, health and safety data and through incident and accident reporting.</p> <p>The registered nurse, staff and health and safety meetings are held monthly and include some aspects of the quality and risk management programme. Resident meetings are held monthly.</p> <p>The managers stated that there are verbal management/director meetings when issues are identified.</p> <p>The managers stated that there is a documented business and quality plan.</p>	<p>Not all data collected is documented in registers that are used to review trends and possible gaps that would lead to opportunities for improvement. Examples include an eye infection documented in an infection control audit that was not documented in the surveillance data and lack of recording of a serious incident in the incident and accident register. ii) The registered nurse, staff and health and safety meetings minutes do not include all aspects of the quality and risk management programme. iii) Management/director meetings are not documented or held regularly. iv) The business and quality plan were not able to be sighted during the audit.</p>	<p>Document all data in registers. ii) Discuss all aspects of the quality and risk management programme through the meetings provided. iii) Minute the management meetings and hold at regular intervals. iv) Document a business and quality plan/s with evidence of implementation and review.</p> <p>90 days</p>

<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	PA Low	<p>The service is expected to complete annual satisfaction surveys with the last collated survey completed in March 2013. Forms were sent out in October 2014 with some returns received.</p>	<p>Complete surveys annually as per the internal audit schedule. li) Collate survey results and document corrective plans if required.</p>	<p>Complete surveys annually as per the internal audit schedule. li) Collate survey results and document corrective plans if required.</p> <p>180 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Moderate	<p>The service has an implemented internal audit schedule. Records indicate that internal audits are completed as scheduled and corrective action plans are documented when issues are identified.</p> <p>A complaint was forwarded via the District Health Board to the service. The District Health Board has responded with actions to be completed. An action plan has been documented however this does not address issues raised in the letter from the District Health Board.</p>	<p>Evidence of resolution against the corrective action plan is not documented. ii) An action plan documented does not relate to the issues raised in the District Health Board letter and there is no information on the plan that identifies the resident, who has documented the plan or date of the plan.</p>	<p>Document evidence of resolution of issues identified in corrective action plans. ii) Document an action plan that addresses issues raised in a letter from the District Health Board and include date of reporting, name and signature of the person writing the plan and identifier related to the resident.</p> <p>180 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly</p>	PA Moderate	<p>Meeting minutes evidence some discussion of risks and some data is documented.</p> <p>The clinical and assistant managers state that issues are discussed in relation to clinical components of service delivery.</p>	<p>Document discussion around clinical aspects of the service and evidence strategies implemented to improve the quality of service delivery. ii) Analyse trends and risks with evidence that these result in improvements in service delivery. iii) Lock staff information in an area that</p>	<p>Document discussion around clinical aspects of the service and evidence strategies implemented to improve the quality of service delivery. ii) Analyse trends and risks with evidence that these result in improvements in service</p>

<p>associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>Staff files are kept in an office accessed by the directors, maintenance staff member and clinical and assistant managers. The key to the cupboard is either left in the cupboard or is kept in the drawer.</p>	<p>is only accessible to staff who are required to see this.</p>	<p>delivery. iii) Lock staff information in an area that is only accessible to staff who are required to see this.</p> <p>180 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA Low</p>	<p>Seven staff files include a signed contract, job descriptions in three files, reference checks in two files. There is an annual appraisal process in place with all staff having a current performance appraisal.</p>	<p>Police checks and reference checks were not documented in files reviewed. A letter of offer and applications for the roles are at time documented.</p>	<p>Document evidence of the recruitment process in all staff files.</p> <p>180 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>One file included a signed and completed orientation checklist.</p>	<p>Evidence of orientation being completed for staff is not documented in six of the seven files reviewed.</p>	<p>Document evidence of completion of orientation for staff.</p> <p>180 days</p>
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes</p>	<p>PA Low</p>	<p>The staffing policy is the foundation for work force planning. The staffing policy was updated to reflect a capacity of 58 residents following the last audit.</p>	<p>The staffing policy does not adequately document staffing requirements i.e. staffing required for full capacity, staffing required if there is an increase/decrease in the number of beds occupied or the</p>	<p>Review the staffing policy to ensure that it reflects alterations in capacity, acuity and allocation of staff to specific areas within the</p>

in order to provide safe service delivery.			allocation of staff to specific wings/units within the service.	service.  90 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>All of the care plans have been rewritten and reviewed in the last six months. Though the care plans are rewritten, there is limited documented evidence that the care plans had been evaluated before the new care plan is developed. In the five resident files reviewed, (two hospital and three rest home), one of these had an evaluation of care that is documented in the last six months. The other files have the last documented care evaluation of between nine and 18 months intervals. The five resident files record that the needs of the residents are been met. The clinical manager interviewed reports that evaluation of the previous care plan and residents needs does occur as part of the process of re-writing the new care plan. The shortfall is in the requirement to ensure the care plan evaluations are documented at least six monthly.</p> <p>The families of both the residents reviewed using tracer methodology did report that they are overall satisfied with the care provided. These families both report that they needed to initiate or prompt the staff to identify and respond to the changing needs of their relatives.</p>	<p>Three of the five resident files reviewed do not have a documented evaluation conducted within the last six months.</p> <p>The families of both the residents reviewed using tracer methodology report that they had to prompt the staff to respond to the changing condition of their relatives.</p>	<p>Provide evidence and ensure that care plan evaluations are documented at least six monthly.</p> <p>Provide evidence and ensure that staff respond in a timely manner to assess and provide care that meets the residents changed needs.</p> <p>180 days</p>

		<p>The other families spoke highly of the quality of provision of care. The progress notes of both these residents record that the staff identified the changes with the resident, but did not record that the staff acted on these changes till the families prompted further actions, especially if changes have occurred after hours (such as medical review, admission to hospital and engaging a mobile X-ray service). The GP reports that they feel that all residents are receiving safe and appropriate care and reported that the clinical manager has 'excellent' clinical judgment and nursing skills. One rest home resident reports that care and services provided at St Patricks have assisted them to regain their mobility, and speaks highly of the quality of care. There is overall satisfaction with the quality of care provided at St Patricks, there is a required improvement in ensuring the changing needs of the residents are identified and actioned in a timely manner by the staff.</p>		
<p>Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.</p>	PA Low	<p>Trolleys containing chemicals are kept at the top of the stairs accessed by staff, family and residents and in a room that was unlocked on the day of the audit in the main building.</p>	<p>Chemicals are not kept in a safe place when unattended</p>	<p>Keep chemicals in a safe place at all times.</p> <p>60 days</p>

<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>PA Low</p>	<p>The surveillance data from January to May 2014 records the number of urinary infections and compares the results for the rest home and hospital. The data records the number of urinary tract infections for the rest home and hospital residents over this time. The data identifies that there are no skin, respiratory, eye or gastroenteritis in this time. Though infection surveillance data is collected, it does not reflect the number of infections that are identified in other forms of documentation (refer to 1.2.3.6). There is no documented analysis of the data, trend analysis of the data or action plans on how to address or reduce infections.</p>	<p>There is no documented evidence that the infection surveillance data is trended and that outcomes to reduce infections are acted upon, evaluated and reported to relevant staff and management.</p>	<p>Document the analysis of the surveillance data to include trend analysis and that action plans are developed and acted upon.</p> <p>180 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display
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End of the report.