Calvary Hospital Southland Limited

CURRENT STATUS: 13-Jun-12

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Certification audit conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.

GENERAL OVERVIEW

Calvary hospital is a 66 bed hospital and rest home facility with a strong catholic history reflected in the documentation and practice of the organisation, however, all denominations are welcomed in this Invercargill facility. Governance is provided by a board with clear separation from operational management provided by an experienced registered nurse (RN), who is relieved during any absence by a clinical co-ordinator (RN). There are nine other RNs to provide cover for all shifts. The philosophy is of 'not for profit' which enables the board to employ a physiotherapist, dietitian and provide extra staffing when consumers are unwell. There is consistently high occupancy and it is because of this the facility is being extended with construction underway and due for completion in October. Three of the four reconfigured beds are currently being used for hospital residents. All rooms identified are of adequate size and configuration to allow for hospital residents, and the call bell system is consistent throughout the facility (rest home and hospital wings) so it can be heard by all staff on any shift.

There are 20 areas for improvement required relating to: quality and risk systems, safe regulation of heating the environment, restraint minimisation and ensuring signed admission agreements, ensuring enrolled nurses meet their scope of practice, documentation in care plans, assessments and evaluations, and three areas in infection control relating to the manual, surveillance and training records.

AUDIT SUMMARY AS AT 13-JUN-12

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service attained with some criteria exceeded
	No short falls	Standards applicable to this service attained with all criteria achieved

Indicator	Description	Definition
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Standards applicable to this service attained but with some criteria partially achieved and of negligible or low risk
	A number of shortfalls that require specific action to address	Standards applicable to this service attained but with some criteria partially achieved and of medium, high or critical risk and/or some criteria unattained
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained

Consumer Rights	Day of Audit 13-Jun-12	Assessment
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.		**No short falls**

Organisational Management	Day of Audit 13-Jun-12	Assessment
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 minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity**

Continuum of Service Delivery	Day of Audit 13-Jun-12	Assessment
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.		**A number of shortfalls that require specific action to address**

Safe and Appropriate Environment	Day of Audit 13-Jun-12	Assessment
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.		**A number of shortfalls that require specific action to address**

Restraint Minimisation and Safe Practice	Day of Audit 13-Jun-12	Assessment
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		**Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity**

Infection Prevention and Control	Day of Audit 13-Jun-12	Assessment
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.		**Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity**

AUDIT RESULTS AS AT 13-JUN-12

Consumer Rights

Staff demonstrate a knowledge of the Health and Disability Commissioner's (HDC) Code of Health and Disability Serviceds Consumers' Rights (the Code). Information on the Code and advocacy services is displayed throughout the service. The privacy of residents is maintained. The service has ten double rooms and the rest are single rooms. Those in double rooms have their privacy maintained. The service is a catholic health care facility and the spiritual needs of residents are met. The service also provides care for all denominations. Residents, family and staff interviewed confirm residents are not subject to abuse or neglect. The service has policies to ensure residents are not subjected to discrimination, coercion, harassment and sexual or other exploitation. The service has policies and procedures and links to external Maori health care services. Residents and their families are advised of incidents and changes in the residents' health status. Translation

services are available if required. Residents are provided with written and verbal information to make informed choices and provided with the opportunity to express their wishes regarding resuscitation. Residents are advised of the advocacy service; the service has policies regarding advocacy and staff have an understanding of the advocacy service. There is no restriction on visitors and the service has links with the wider community. There is a complaints policy that complies with the Code and is accessible for staff, family and consumers.

Organisational Management

Governance is the responsibility of the board and there is clear separation of the governance role and operational management. The facility registered nurse (RN) manager has been in the position for three years and has previous management experience to support her role. There is a clinical co-ordinator (RN), other RNs and enrolled nurses (EN), who are responsible for co-ordinating consumers care and ensuring the day to day needs of residents are met. Services are planned to meet the needs of consumers. Four family and nine consumers interviewed confirm they are involved in service planning and services are provided that meet their needs.

There is a documented organisation wide quality and risk management plan. The purpose, values, goals and scope are documented within the plan and underpinned by the detailed mission statement. The clinical management team oversees the needs of the consumers and written reports are provided to the governance board. The quality and risk management programme is aimed to facilitate service improvement through documented quality improvement practices and includes policy and procedures, adverse event reporting, complaint management, infection prevention practices, hazard identification, internal audits, satisfaction surveys and staff and consumer feedback. Regular meetings occur at governance level, management, clinical and staff level, and specific service areas also hold regular meetings. There is a documented training programme in place. There are two areas for improvement identified relating to key components of service delivery being linked to the quality and risk management system and quality improvement data is required to be analysed and evaluated.

There is a skills mix personnel policy, and position descriptions for all areas of service delivery. Policies and procedures are in place to ensure staffing levels and a suitable mix to meet consumer needs. Skill and acuity is taken into consideration when rostering. Staff state there is adequate staffing on all shifts. There is a RN on duty at the facility for every shift. Annual performance appraisals occur, and all RNs, ENs and the facility's physiotherapy and dietitian practising certificates are current. There is one area for improvement identified relating to new care staff receiving an orientation that covers key components of service delivery.

Residents files contains relevant, up to date and legible information and clinical files are intergrated. Records of past and present residents are maintained. Residents files are stored in a manner which ensure confidentiality can be maintained. The facility has a documented and implemented archive process, and archived records are easily retrieved.

Continuum of Service Delivery

The service has a documented access and entry criteria that is communicated to those making an enquiry and referral agencies. An inmprovement is required because a record is not maintained of potential residents who are declined entry.

Assessments are being undertaken by registered nurses and enrolled nurses and an improvement is required in relation to this, to ensure that registered nurses are undertaking this responsibility as required. Residents and family members interviewed confirm their health and health care needs are discussed with them and they are involved in the planning of care, however this is not always documented. Residents are reviewed at least every three months by the general practitioner. There is no documentation to indicate that three monthly reviews are appropriate. The service has a range of assessment tools and assessments are conducted in privacy. The service has several documents that outline the plan of care for each resident. The care plans are clearly documented and available in each resident's clinical file. Two improvements are required as goals are not always documented and care plans do not always outline the interventions required. Residents interviewed confirm the care provided meets their needs. The service has links with external providers. There is a comprehensive activities programme and residents interviewed enjoy the activities offered.

Care plans are evaluated regularly and outcomes are documented, however an improvement is required as evaluations have not occurred on all assessments. The service refers to a range of external services and residents are involved in the referral process. The service has a process for discharge and transfer of residents.

Systems are in place for the prescribing, dispensing, storage and administration of medication. The robotic and blister medication packs are used by the service. Staff are assessed as competent to administer medication. Improvements are required because there are no specimen signatures for the general practitioner, one entry in the controlled drug register has not been adequately completed and the current system in place to facilitate the self administration of medication does not meet medication guidelines.

Safe and Appropriate Environment

The facility is a single storey well maintained brick building with large spacious indoor and outdoor areas that are easily accessed. A documented maintenance programme ensures all buildings, plant and equipment is maintained. There is a building current warrant of fitness for the existing building An extension to the facility has commenced and is due for completion in October. The construction is fenced and does not impact on the current premise environment except for the decommission of one room that is secure. All amenities, fixtures, equipment and furnishings are selected and maintained with consideration of the consumer group. All consumers' rooms within the facility contain a hand basin, and all those in the hospital wing contain full ensuites either individually or between and shared with another room. There are several rest home rooms with full ensuites. The facility also has adequate numbers of identifiable communal shower and toilet facilities including those close to communal lounge and dining areas. Consumers bedrooms and hallways are very spacious, clean tidy and well maintained. Doors in the hospital wing are double opening doors to facilitate ease of access.

Emergency management and fire safety is documented, alternative utilities and supplies are available on site, and emergency training is included as regular staff training. There are appropriate security measures in place. There is appropriate heating and ventilation throughout the facility. There is one area for improvement identified relating to the temperature of wall heaters in one wing of the facility.

Restraint Minimisation and Safe Practice

Policies and procedures are in place that meet the requirements of the standards. On the day of the audit there are four restraints in use for consumers which are documented, implemented and reviewed according to policy. The RN restraint co-ordinator assesses and ensures the implementation of the restraint minimisation practice and the facility demonstrates the safe use of restraints. Consumers and family/whanau are included in restraint and enabler reviews as appropriate. There is a restraint approval group that meets six monthly. Two areas required for improvement include training for all staff in relation to restraint minimisation and safe practice and assessing staff as competent in restraint practice.

Infection Prevention and Control

The service has an infection control committee which meets regularly as part of the quality management meeting. Management are kept informed of infection prevention and control matters through meeting attendance and reports provided by the infection control nurse. A registered nurse is employed two days a month to fulfil the role of infection control nurse; this role is supported by the recent appointment of an assistant. The infection control nurse is responsible for the implementation of the infection control programme and has the necessary range of skills required. The service has a documented infection control programme, policies and procedures. Improvement is required as the infection control programme is not reviewed annually.

External advise is available if required for any infection prevention and control matters. Staff are provided with infection control education. An improvement is required as records of staff attendance at infection control education sessions are not adequately maintained.

The service undertakes surveillance activities and infections are collated and reported on monthly. Infection rates are collected separately for the rest home and hospital. An improvement is required in relation to surveillance.