# CHT Healthcare Trust - St Johns

## Current Status: 12 June 2014

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

## General overview

St John’s Hospital provides residential care for up to 70 residents at hospital and residential disability (physical) level care. There were 70 residents on the day of the audit with nine of these residents receiving residential disability level care. This audit also included assessing the service as suitable to provide residential disability (physical) level care.

The facility is operated by the Christian Healthcare Trust (CHT). The CHT group has strong board and effective governance practices. The current manager is a registered nurse who has been in the role for eight years. She is supported by a clinical coordinator, who is a registered nurse and has been at the facility for eight years and in this role for seven years; and the area manager who is also a registered nurse. Resident and family feedback during the audit was very positive. A well-developed staff education programme is implemented, with compulsory external Aged Care Education (ACE) programme enrolment, for new staff training.

Three of the four shortfalls identified in the previous audit have been addressed. These were around complaints management, evaluations and medication administration. Further improvements are required around wound management.

This audit has identified further areas for improvement around informing families of incidents, care planning, assessments, restraint monitoring and aspects of medication documentation.

## Audit Summary as at 12 June 2014

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 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 |
|  | 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 |

### Consumer Rights as at 12 June 2014

|  |  |  |
| --- | --- | --- |
| 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Organisational Management as at 12 June 2014

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

### Continuum of Service Delivery as at 12 June 2014

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 12 June 2014

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

### Restraint Minimisation and Safe Practice as at 12 June 2014

|  |  |  |
| --- | --- | --- |
| 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. |

### Infection Prevention and Control as at 12 June 2014

|  |  |  |
| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under 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).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | CHT Healthcare Trust |
| **Certificate name:** | CHT Healthcare Trust - St Johns |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | St Johns Hospital |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric) |
| **Dates of audit:** | **Start date:** | 12 June 2014 | **End date:** | 12 June 2014 |

**Proposed changes to current services (if any):**

This audit has verified that the service is able to provide residential disability level care. Currently nine residents are receiving this level of care.

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 70 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXX | **Hours on site** | 8 | **Hours off site** | 4 |
| **Other Auditors** | XXXXXX | **Total hours on site** | 8 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXX |  |  | **Hours** | 1 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 9 | Total audit hours | 25 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 11 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 64 | Number of relatives interviewed | 6 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

|  |  |  |
| --- | --- | --- |
| a) | I am a delegated authority of Health and Disability Auditing New Zealand Limited | Yes |
| b) | Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health and Disability Auditing New Zealand Limited has finished editing the document. | Yes |

Dated Tuesday, 1 July 2014

## **Executive Summary of Audit**

**General Overview**

St John’s Hospital provides residential care for up to 70 residents at hospital and residential disability (physical) level care. There were 70 residents on the day of the audit, nine of these were receiving residential disability level care. This audit also included assessing the service as suitable to provide residential disability (physical) level care. The facility is operated by CHT, the CHT group has strong board and effective governance practices. The current manager is a registered nurse who has been in the role for eight years. She is supported by a clinical coordinator who is a registered nurse and has been at the facility for eight years and in this role for seven years, and the area manager who is also a registered nurse. Resident and family feedback during the audit was very positive. A well-developed staff education programme is implemented with compulsory external (ACE programme) enrolment for new staff training.
Three of the four shortfalls identified in the previous audit have been addressed. These were around complaints management, evaluations and medication administration. Further improvements are required around wound management.

This audit has identified further areas for improvement around informing families of incidents, care planning, assessments, restraint monitoring and aspects of medication documentation.

**Outcome 1.1: Consumer Rights**

There is an open disclosure policy which describes ways that information is provided to residents and families/representatives at entry to the service continually and as required. Family are involved in the initial care planning and receive and provide on-going feedback. Regular contact is maintained with family including if a change in residents health status occurs. There is an improvement required around informing families of incidents. The service has documented complaints and there is evidence of follow up. This is an improvement since the previous audit. The complaints register reviewed included verbal and written complaints.

**Outcome 1.2: Organisational Management**

St John’s has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management.
Quality information is reported to monthly combined staff and quality meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at six monthly resident meetings and via annual satisfaction surveys. The resident satisfaction survey shows a high level of satisfaction. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. St John’s has job descriptions for all positions that include the role and responsibilities of the position. There is an annual in-service training programme that has been implemented for the year and staff are supported to undertaken external training. The service has a documented rationale for determining staffing and health care assistants, residents and family members report staffing levels are sufficient to meet resident needs.

**Outcome 1.3: Continuum of Service Delivery**

Registered nurses are responsible for each stage of service provision. The sample of residents' records reviewed provides evidence that the provider has systems to assess the care needs of the residents. Care plans are developed in VCare (computer programme) and demonstrate service integration. Care plans are rewritten six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals. Residents are assessed within set timeframes and receive well planned and co-ordinated services.

There is an activities programme that operates over seven days, which offers a variety of activities suited to the needs of the residents. The activities programme is facilitated by two activities co-ordinators. The activities programme provides varied options and activities which are enjoyed by the residents. Community activities are encouraged and van outings are arranged on a regular basis.
Medicines are managed via the robotics system and policies reflect legislative requirements. The medicines records reviewed include documentation of allergies and sensitivities and these are highlighted. Education and medicines competencies are completed by all staff responsible for administration of medicines. Staff that administer medicines have been assessed as competent.
All food is cooked on site by the cook. All residents' nutritional needs are identified, documented and choices available and provided. Meals are well presented, homely and the menu plans are reviewed by an independent dietitian annually.
 This audit has identified improvements required by the service around the use of assessments, care plan interventions, restraint monitoring medication management.

**Outcome 1.4: Safe and Appropriate Environment**

The building is purpose built. Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature. There is current building warrant of fitness.

**Outcome 2: Restraint Minimisation and Safe Practice**

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently five residents requiring restraints and three residents using enablers. Staff are trained in restraint minimisation and challenging behaviour management.

**Outcome 3: Infection Prevention and Control**

The infection control coordinator is a registered nurse. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 13 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 2 | 1 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 60 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.9: Communication | Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.9.1 | Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Four of 11 incident forms sampled do not have evidence on the incident form or in the progress notes that family have been informed of the incident. | Ensure family are informed of all incidents. | 180 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions  | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | One of six files sampled did not have the risk assessments completed within the required time frame Two of six files sampled did not have detailed interventions in the care plan for identified needs. One resident using a lap belt (enabler) did not have a risk assessment or consent form completed for the use of the lap belt.Two of three restraint monitoring forms sampled had at least one eight hour period in the previous five days where no restraint monitoring had occurred.Two of seven wound care plans reviewed did not have comprehensive wound assessments documented. One resident with a pressure area had no interventions documented to minimise the pressure injury risk  | Ensure that all risk assessment required on admission are completed within the required time frames.Ensure all care plans have detailed interventions to manage identified needs and risks. Ensure all residents using enablers have the required risk assessments and consents completed. Ensure that all residents using restraints have the required monitoring completed and documented.Ensure that all wounds have comprehensive wound assessments documented. .  | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management  | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.6 | Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Low | Eleven of twelve medication charts sampled have PRN medications prescribed with no indications for use documented.  | Ensure medications charted have indications for use documented, which are specific for that for that resident. | 90 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.1: Consumer Rights**

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

#### Standard 1.1.9: Communication **(**HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

**Attainment and Risk:** PA Low

**Evidence:**

Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Eleven incidents/accidents forms were viewed for seven residents. The forms include a section to record family notification. Seven of 11 forms indicated family were informed or if family did not wish to be informed. This is an area requiring improvement. On interview seven residents (including two under 65 years old), six family members, seven health care assistants, two registered nurses and the clinical coordinator all stated that family are informed following changes in the residents’ health status.
The registered nurses interviewed stated that they record contact with family/whanau. Contact records were documented in all files reviewed.
Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.
A residents meeting occurs six monthly and issues arising from the meeting are fed back to staff meetings. Issues raised generate an investigation and corrective action plan. In July 2013, the area manager met with families and residents to provide feedback following the resident and family survey.
There is a policy that describes the availability of interpreter services when required.
D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry
D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.
D16.4b: Six family members stated that they are always informed when their family members health status changes.
D11.3: The information pack is available in large print and advised that this can be read to residents.

##### **Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)**

Consumers have a right to full and frank information and open disclosure from service providers.

**Attainment and Risk:** PA Low

**Evidence:**

Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Eleven incidents/accidents forms were viewed for seven residents. The forms include a section to record family notification. Seven of 11 forms indicated family were informed or if family did not wish to be informed. On interview seven residents (including two under 65 years old), six family members, seven health care assistants, two registered nurses and the clinical coordinator all stated that family are informed following changes in the residents’ health status.

**Finding:**

Four of 11 incident forms sampled do not have evidence on the incident form or in the progress notes that family have been informed of the incident.

**Corrective Action:**

Ensure family are informed of all incidents.

**Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)**

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.1.13: Complaints Management  **(**HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

**Attainment and Risk:** FA

**Evidence:**

The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with seven residents inform an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.
There is a complaints register that includes all complaints for 2014. Complaints for 2014 to date were reviewed (there have been seven complaints in 2014 to date). Verbal and written complaints are documented.
All complaints have noted investigation, time lines, corrective actions when required and resolutions. Results are feedback to complainants. All complaints have been acknowledged within the required timeframe and this is an improvement since the previous audit.
Discussions with seven residents and six family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns. Discussions with seven health care assistants stated that concerns/complaints were discussed at monthly staff /quality meetings.
There have been no external complaints.

D13.3h: A complaints procedure is provided to residents within the information pack at entry.

##### **Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)**

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)**

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **Outcome 1.2: Organisational Management**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

#### Standard 1.2.1: Governance **(**HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

**Attainment and Risk:** FA

**Evidence:**

St John’s Hospital provides residential care for up to 70 residents at hospital and residential disability level care. There were 70 residents on the day of the audit – nine of these are receiving residential disability level care. St John’s is certified to provide medical services under the hospital component of its certificate. At the time of the audit, there were no residents under this category of care. The facility is operated by CHT. The CHT group has strong board and effective governance practices.
St John’s has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year and aligns with the CHT operational strategic goals and business plan for 2014. The quality process being implemented includes regularly review of policies, an internal audit programme and a health and safety programme that includes hazard management. Goals and objectives are included in the plan and mechanisms for monitoring progress are outlined. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Combined staff /quality / health and safety / restraint discuss key components of the quality system and any issues are reported. There is a six monthly internal audit completed by the area manager and corrective action plans are used to manage shortfalls.
The current manager is a registered nurse who has been in the role for eight years. She is supported by a clinical coordinator who is a registered nurse and has been at the facility for eight years and in this role for seven years and the area manager who is also a registered nurse. The manager and the clinical coordinator share on-call. Job descriptions for the manager and the clinical coordinator outline their authority, accountability and responsibility. The manager and the clinical coordinator have completed on-going training appropriate to their positions. There is registered nurse (RN) cover in the facility 24/7.
ARC, D17.4b (hospital): The manager and clinical coordinator have maintained at least eight hours annually of professional development activities related to managing a hospital.

##### **Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)**

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)**

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.3: Quality And Risk Management Systems **(**HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

**Attainment and Risk:** FA

**Evidence:**

St John’s has a quality framework that is being implemented. The manager is directly involved in operations at the facility and the clinical coordinator (RN) supports her in this role. There is a current business plan that includes goals and a quality assurance plan which includes internal audit, incident collation, infection surveillance and hazard management. Interview with all staff (seven healthcare assistants, two registered nurses and the clinical coordinator and manager); inform an understanding of the quality activities undertaken at St John’s.
Resident meetings occur six monthly (minutes viewed). Seven residents interviewed are aware meetings are held. Annual surveys are conducted of residents and relatives. All residents and relatives interviewed stated they are asked for feedback regarding the service. At the time of audit resident and relative feedback indicated satisfaction with the service. The resident satisfaction survey shows resident satisfaction is in the 77.9th percentile across 71 similar facilities in Australasia in 2013.

D5.4: The service has policies/ procedures to support service delivery.
D10.1: Care of the deceased resident procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary
 certifications and documentation is completed in a timely manner.
D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.
D19.2g: Falls prevention strategies such as physiotherapy reviews and instruction around prevention in care plans.

Policies and procedures are in place with evidence of review. The manager and clinical coordinator manage quality systems. All staff are invited to attend the quality, health and safety meetings. The quality programme is reviewed annually and is being implemented. Information is reported through the monthly staff /quality meetings. Meetings include key components and standing agenda items of the programme include audit, infection, incidents, complaints and health and safety.
Policy and procedure documents no longer relevant to the service are removed and archived. Documentation is archived in a locked facility.
Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the
complaints register. An infection rate monthly summary is completed. There is a hazard register that is reviewed annually. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. Restraint and enabler usage is documented. St John’s has five residents requiring restraints and three residents using enablers.
The area manager completes a comprehensive spot audit of the service six monthly. All issues found in the January 2014 spot audit (two issues) have identified corrective action plans and resolutions.
Monitoring data that is collected by way of monthly: incident report, infection collation, and outcomes from internal audits is reported through to quality and staff meetings (when these occur). Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and implementation. All staff interviewed could describe the corrective action process. The facilities monitoring activities, link to the means of achieving objectives as outlined in the quality programme.
St John’s has policies and procedures that describe the management of risks. There is a hazard register that is reviewed yearly. Hazard forms are available for use and are seen to be utilised. Six health care assistants interviewed are aware of hazard reporting. The service is seen to be proactive in minimising/eliminating environmental hazards/risk.

##### **Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)**

The organisation has a quality and risk management system which is understood and implemented by service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)**

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)**

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)**

Key components of service delivery shall be explicitly linked to the quality management system.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)**

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

A process to measure achievement against the quality and risk management plan is implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)**

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)**

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(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;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.4: Adverse Event Reporting  **(**HDS(C)S.2008:1.2.4)

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

**Attainment and Risk:** FA

**Evidence:**

There is a policy that describes accident/incident management. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported the immediate actions taken are documented in incident forms. All 11 incident forms sighted are fully completed with dates and the information aligns with progress notes. The incidents forms are then reviewed and investigated by the manager or clinical coordinator who monitor issues. All 11 incident forms sighted and have been signed by a registered nurse. If risks are identified these are also processed as hazards. Incidents are collated monthly and reported to the quality, health and safety meetings.
Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification.
Eleven incidents/accidents for seven residents were viewed. Incidents are collated monthly onto a reporting sheet to monitor issues and trends. Preventative and corrective actions are documented as required. Actions are reflected in residents long term care plans (LTCP). If risks are identified these are also processed as hazards.
D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

##### **Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)**

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.7: Human Resource Management  **(**HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

**Attainment and Risk:** FA

**Evidence:**

There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. These are kept in individual staff files. All staff have employment contracts. The practising certificates of RN’s are current. The service also maintains copies of other visiting practitioner’s certification including GP, pharmacist, physiotherapist and podiatrist. Appointment documentation is seen on file including signed contracts, job descriptions, orientation, reference checks and training. There is an annual appraisal process in place and appraisals are current in five of five files reviewed.
There is a training/induction process that describes the management of orientation. Newly appointed staff complete an orientation that was sighted in all files reviewed. Interviews with seven health care assistants described the orientation programme that includes a period of supervision. The healthcare assistants reported that supervision can be extended if needed. This was verified by the manager. The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance recorded at sessions kept. Interview and seven health care assistants inform there is access to sufficient training. Medication competencies are completed for all staff who administer medication. These are checked by the clinical coordinator.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication.

##### **Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)**

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)**

The appointment of appropriate service providers to safely meet the needs of consumers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)**

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.8: Service Provider Availability  **(**HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

**Attainment and Risk:** FA

**Evidence:**

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Healthcare assistants reported that staffing levels and the skill mix was appropriate and safe. All residents and family members interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that the manager and the clinical coordinator will be on-call at all times, that at least one staff member on duty will hold a current first aid qualification and that new staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. The clinical coordinator covers the managers during absences and holidays. Residents and relatives interviewed stated they felt there were sufficient staff to meet the needs of residents.

##### **Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)**

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **Outcome 1.3: Continuum of Service Delivery**

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.

#### Standard 1.3.3: Service Provision Requirements **(**HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

**Attainment and Risk:** FA

**Evidence:**

Six client files were sampled. An admission checklist is completed. The organisation clearly identifies and communicates the level of detail within policies, to meet current accepted good practice and meet legislative requirements. Residents are assessed initially for; a) risk of falls, b) risk of pressure areas, c) continence, d) pain (where appropriate), e) MNA, and a depression scale. Care plan reviews had occurred within the required timeframes in five of six files sampled. One of six files sampled was a new admission and was not due for review. Doctors’ visits and allied health notes (physiotherapist, dietitian, podiatrist etc.) are included in resident files. Assessment/monitoring forms such as continence monitoring, risk of falls, risk of pressure areas and pain management wound management, are available. Seven caregivers and two registered nurses interviewed could describe 'hand over' which occurs at the change of each shift.
The service has a variety of ways in which they ensure that the service is co-ordinated. Residents' progress notes are updated daily and these are readily available for all staff and allied health professionals to see. Staff meetings provide further opportunities for service co-ordination. Twelve of the twelve resident medication records sampled show that the medicines have been reviewed three monthly.
The GP interviewed on the day of audit stated that care was well co-ordinated and was of a high standard.

Tracer Methodology - Residential Disability

*XXXXXX This information has been deleted as it is specific to the health care of a resident*

Tracer Methodology – New Admission

*XXXXXX This information has been deleted as it is specific to the health care of a resident.*

##### **Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)**

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.6: Service Delivery/Interventions  **(**HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

**Attainment and Risk:** PA Moderate

**Evidence:**

St John’s provides services for residents requiring hospital and residential disability (physical) level care. Residents' care plans are completed in V-care (computer programme) by the registered nurses. Six client files were sampled. Improvements are required in the use of assessments, care plan interventions, and restraint monitoring (link 1.3.6.1). When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation.
Six of six care plans sampled evidenced six monthly care plan reviews. The care being provided is consistent with the needs of residents; this is evidenced by discussions with seven caregivers, six family/whanau members, two RNs, the clinical co-ordinator, the manager and the area manager.
There is evidence of referrals to specialist services such as podiatry, physiotherapy, dietitian, wound care specialist nurse and the gerontology nurse specialist. The two RN’s and the clinical co-ordinator interviewed were able to describe the process for referral to specialist services.

In five of six files sampled there was evidence of the use of short term care plans for infections, challenging behaviours and weight loss. Two of the six files sampled did not have detailed interventions for the identified needs e.g. resident noted to have aggressive outbursts but no interventions documented to identify triggers or de-escalation techniques, resident required a lip plate but this was not documented in the care plan. This is a further area requiring improvement.

In one additional file sampled the resident was using a bedrail as an enabler and a lapbelt. The risk assessment and consent was completed for the enabler bed rail but not for the lap belt. Two of three restraint monitoring forms sampled have at least one eight hour period in the past five days where no restraint monitoring occurred. This also requires improvement.

Five of six files sampled had evidence of the appropriate use of assessment tools to inform the care plan e.g. (fall risk assessment, Waterlow, Abby pain scale, and behaviour monitoring chart, MNA, food and fluid balance). One of six files sampled for a resident recently admitted did not have all risk assessments completed on the day of audit. This is a further area requiring improvement.

D18.3 and 4: Dressing supplies are available and the staff reported they had all the necessary equipment they required to provide care.

Improvement was noted in the documented timeframes for review of wounds from the previous audit. Seven of seven wound care plans reviewed showed documented management plans and timeframes for review of the wound. Two of seven wound care plans reviewed did not have wound assessments completed describing the size of the wound, the exudate, the presence of absence of odour, and the condition of the wound bed and or surrounding skin. This is an area requiring improvement.

The GP stated he was consulted appropriately in the management of wounds. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.

##### **Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)**

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

**Attainment and Risk:** PA Moderate

**Evidence:**

Residents' care plans are completed by the registered nurses with input from the resident and their family. When a resident's condition alters, the registered nurse initiates a review and if required, contacts the GP. Six of six families interviewed stated they were kept well informed of any changes in health status. Six of six files sampled showed evidence that the resident had been consulted about the development of the care plan which was confirmed in the resident interviews. Six of six residents and seven of seven families spoken to, reported being very satisfied with the care being provided.
Seven of seven wound care plans reviewed showed documented management plans and timeframes for review of the wound.

One resident with a pressure area documented on the wound register did not have a care plan intervention in place to minimise the pressure area risk.

**Finding:**

One of six files sampled did not have the risk assessments completed within the required time frame

Two of six files sampled did not have detailed interventions in the care plan for identified needs.

One resident using a lap belt (enabler) did not have a risk assessment or consent form completed for the use of the lap belt.

Two of three restraint monitoring forms sampled had at least one eight hour period in the previous five days where no restraint monitoring had occurred.

Two of seven wound care plans reviewed did not have comprehensive wound assessments documented.

One resident with a pressure area had no interventions documented to minimise the pressure injury risk

**Corrective Action:**

Ensure that all risk assessment required on admission are completed within the required time frames.

Ensure all care plans have detailed interventions to manage identified needs and risks.

Ensure all residents using enablers have the required risk assessments and consents completed.

Ensure that all residents using restraints have the required monitoring completed and documented.

Ensure that all wounds have comprehensive wound assessments documented. .

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.7: Planned Activities **(**HDS(C)S.2008:1.3.7)

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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

**Attainment and Risk:** FA

**Evidence:**

There are two activities co-ordinators employed 60 hours per week Monday to Friday. The occupational therapist has recently resigned and the service is seeking to recruit to this vacant position. Residents have a comprehensive assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career and family. Six of six files sampled showed that recreation/activities assessments and reviews are up to date.
Activities are planned each month and are age appropriate. Programmes are meaningful and reflect ordinary patterns of life. Programmes were sighted up on notice boards and in resident’s rooms. There are visits from school groups and choirs, and the service has a number of volunteers from the community who visit and interact with residents. The activities programme includes activities such as: housie; bowls; reminiscing; newspaper reading; outings including shopping; entertainment; falls prevention exercises; quizzes and word games; hand and foot massages; crafts; art; movies. The facility has access to a van and outings are organised at least twice a month. Those driving the van have current driving licenses and first aid certificates. Discussion with residents confirmed that activities are varied, flexible to meet the needs of residents and enjoyable. Families interviewed state they are able to join in activities. Residents interviewed state they can discuss any suggestions to the activities coordinators.

D16.5d: Six of six resident files reviewed identified that the individual activity plan is reviewed as part of the care plan review

##### **Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)**

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.8: Evaluation  **(**HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

**Attainment and Risk:** FA

**Evidence:**

The care plan policy includes the evaluation requirements. Records of regular reviews with the GP have been maintained.
D16.4a Care plans are reviewed six monthly or more frequently when clinically indicated in the form of a new assessment and new care plan. Improvement has been noted in the care plan evaluations since the previous audit. In five of six care plans reviewed the care plan evaluations are documented at a level that indicates the progress towards meeting the desired outcomes. One of six files sampled was for a new admission and was not due for review.

D16.3c: All initial care plans were evaluated and the long term care documented by the RN within three weeks of admission.

##### **Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)**

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.12: Medicine Management  **(**HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

**Attainment and Risk:** PA Low

**Evidence:**

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in line with accepted guidelines. The afternoon shift RN reconciles the medication on arrival from the pharmacy. The service uses the robotic sachet system.

There are weekly checks of the controlled drug register. Medication errors are reported and managed through the incident reporting process. All opened eye drops are labelled.

A pharmacy contract is in place and the pharmacy is available for advice and support, as and when required. Unused or expired medicines are taken back to the pharmacy for appropriate disposal.

All staff responsible for medicine management are competent to perform this function. All those deemed competent have completed documented medication competencies. Staff competencies are completed. There is a sample list of signatures and the registered nurses interviewed described their responsibilities in regard to medication administration.

The medications systems procedure includes a section "where residents are responsible for their own medication". This states a) "Store the medicines, including Controlled Drugs, in the resident’s room in a locked cupboard or drawer that is accessible to the resident and staff and b) Medicines should be checked every week. Appropriate senior staff and the doctor must assess a resident’s ability to take their own medicine at least every three months using SM172.Frm Self-Medication Checklist. Alerts are to be entered for all residents who are self-medicating. These alerts will be printed on the duty report. The service currently has no residents self-medicating.

All documents and signing sheets are completed in ink and legible. An improvement since the previous audit has been noted in the signing for non-packaged medication and all charts sampled evidenced medication being administered as prescribed and being signed for when administered.

Twelve out of twelve resident medication charts reviewed had photo identification. Allergies//adverse reactions and duplicate names are noted. The signing sheets for PRN, oral medications and controlled drugs are correctly signed. An improvement is required around documenting indications for use for as required medications.

On the day of audit an RN was observed administering medication following the accepted medication administration guidelines. The two RN’s and the clinical co-ordinator were able to describe their responsibilities in the safe administration and management of medication.

D16.5.e.i.2; Medications are reviewed three monthly or as required by the G.P in twelve of twelve medication files reviewed.

##### **Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)**

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)**

The facilitation of safe self-administration of medicines by consumers where appropriate.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)**

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

**Attainment and Risk:** PA Low

**Evidence:**

D19.2 d Medication is managed safely and appropriately in line within accepted guidelines. Twelve medication charts were sampled. All medication charts reviewed identified that the GP had seen the resident and reviewed the medication chart three monthly and all medication had been signed for. Medication profiles are computer generated and are legible, up to date and reviewed at least three monthly by the GP.

**Finding:**

Eleven of twelve medication charts sampled have PRN medications prescribed with no indications for use documented.

**Corrective Action:**

Ensure medications charted have indications for use documented, which are specific for that for that resident.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.13: Nutrition, Safe Food, And Fluid Management **(**HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

**Attainment and Risk:** FA

**Evidence:**

The CHT food service procedure provides information to staff about the food service procedure. Food services are contracted out and cooked on site by Medirest services. Policies on food service are developed and implemented. These policies and practices meet the requirements of the food hygiene regulations act 1974. There is a summer and winter menu approved by the Medirest dietitian. Four week menus for summer and winter are appropriate and varied. The contracted food services dietitian makes changes to the menu.
D19.2: Medirest employs an area manager (who oversees nutritional services), a head chef, a 2 IC and three kitchen hands, all of which have completed the Medirest food safety programme.
A mini nutritional assessment is completed on admission for each resident and this is reviewed six monthly (link 1.3.6.1 re initial assessments). Nutritional needs for each resident are entered on the care plan. Special diets are available and catered for as are resident preferences.
Dietary information forms are completed on admission and a copy given to the kitchen for their information. The dietary preferences of each resident are displayed on a whiteboard in the kitchen. The food service procedure states "Residents upon admission will have their individual preferences (likes/dislikes), religious and/or cultural requirements assessed by the care staff using SM190.Frm- Dietary Information. This assessment may include input from the family/ whanau where appropriate.
There are copies of resident’s food preferences/ dietary needs in the kitchen and the cook was able to identify which residents required special meals (such as diabetic).

Meals supplied include as routine, breakfast, lunch, dinner, morning tea, afternoon tea and supper. These meals are served at times that reflect community norms. Outside of regular meal times staff will provide a nutritious snack or drink if residents are hungry or thirsty. Extra snacks are provided when needed.
There is a comprehensive quality assurance programme implemented in the kitchen. The following is included monthly; a) food safety audit, b) food temperature monitoring, c) fridge, freezer and dishwasher temps daily, and d) incoming food temps. Medirest operates a 'balanced score card' monitoring process to ensure compliance with the quality process. The kitchen is clean and well maintained.
The main grocery shop occurs weekly according to the menu. Food is stored in the pantry, the fridge and the freezer and temperatures are recorded daily. Food sighted in the fridge, freezer and pantry was covered and dated and raw food was stored below cooked food. Different coloured chopping boards are used for different food types and there is a roster for kitchen cleaning. The kitchen was clean on the day of the audit. The seven residents (including two residents under 65 years old) interviewed and X family interviewed state they are happy with food temperatures and meals provided.
The service uses the Replenish Energy and Protein (REAP) programme. REAP puts a focus on nutrition and 'nutrition alerts' and is an agenda item at nursing and staff meetings. The documented programme has been developed by the Medirest dietitian and provides eligibility criteria and implementation guidelines for each level of REAP. There are 22 residents currently on the REAP programme who receive various levels of food fortification and supplements.

##### **Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)**

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)**

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)**

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **Outcome 1.4: Safe and Appropriate Environment**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

#### Standard 1.4.2: Facility Specifications  **(**HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

**Attainment and Risk:** FA

**Evidence:**

There is a current BWOF that expires on 19 October 2014. The home is warm and well ventilated. All electrical equipment is checked and tagged bi annually this is current. This last occurred in October 2014.
Staff report minor repairs and maintenance in a maintenance book kept at the nurses' station.
Records indicate all maintenance and repairs are addressed in a timely manner.
Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted monthly by an external fire safety contractor and by the maintenance staff as sighted in documentation. There is a maintenance manager who oversees the facility. The manager states that when an issue requiring maintenance is noticed the staff document this on the maintenance sheet. These are checked every day and in most cases, the issue can be repaired or resolved on the same day. Otherwise, the issue is assessed and an action plan developed on the same day. External contractors are engaged to complete work as required. Equipment is calibrated and serviced annually and this last occurred in August 2013.
There is sufficient space so that residents are able to move around the facility freely. The hallways are wide enough with handrails appropriately placed. All resident rooms are large enough to accommodate bed, chairs and lifting equipment. All rooms in all wings have en-suite shower and toilet. Flooring is appropriate, carpet in corridors and rooms vinyl in utility areas, and easily cleaned.
The outside areas are easily accessed to decking with appropriate safety barriers.
Hallways throughout the facility allow residents to pass each other when using walking aids such as walkers. There is non-slip lino in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. There are hand grips in bathroom and toilet areas. Residents were observed on the day of the audit, to independently and safely move around the inside and outside of the facility; other residents were observed to be assisted by staff. The residents interviewed and family members interviewed confirm the physical internal and external environment of the facility is appropriate to the residents' needs.
There is an outside area which is well maintained and safe. Residents were observed to be moving around in external areas with and without mobility, frames and residents interviewed reported that the outdoor areas are well enjoyed.
ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids.

##### **Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)**

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)**

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)**

Consumers are provided with safe and accessible external areas that meet their needs.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

# NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

#### Standard 2.1.1: Restraint minimisation **(**HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

There is a restraint policy. There is a restraint manual applicable to the type and size of the service. The restraint manual includes a section on training that covers policies, procedures, challenging behaviours management, de-escalation techniques, emergency / acute restraint and appropriate use of safety enablers. Restraint training occurs yearly. Challenging behaviour training has been provided. Staff were familiar with the policy and the definition of enablers. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, included definitions, processes and use of enablers.
The restraint manual determines that enablers are voluntary and the least restrictive option. There are five residents requiring restraints and three residents using enablers. Two enabler files were reviewed and included consents and assessments. Link 1.3.6.1 relating to restraint interventions in care plans and restraint monitoring.

##### **Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)**

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

# NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

#### Standard 3.5: Surveillance **(**HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

**Attainment and Risk:** FA

**Evidence:**

Infection monitoring is the responsibility of the infection control (IC) coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at St John’s are appropriate to the acuity, risk and needs of the residents.
The infection control coordinator enters infections on to the infection register and carries out a monthly analysis of the data. The analysis is reported to the monthly staff, / quality meeting and the monthly RN meeting. The infection control coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility.
Internal audit of infection control is included in the annual programme and occurs monthly. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of G.P involvement and laboratory reporting.

##### **Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)**

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*