St Josephs Home of Compassion Heretaunga Limited

Current Status: 9 September 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 Joseph's Home of Compassion Heretaunga provide rest home, hospital and dementia care for up to 78 residents. There were 75 residents at the facility on the day of audit (13 rest home, 46 hospital and 16 dementia care).

The service is managed by an experienced aged care manager who is supported by an assistant manager. Both are registered nurses. There is a clinical leader on seven days a week and 24/7 registered nurses. The residents and family/whanau comment positively on the services received.

The one shortfall identified at the previous audit around medication administration has been addressed. This audit identified further improvements required around weight loss monitoring.

Audit Summary as at 9 September 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 9 September 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.		Standards applicable to this service fully attained.

Organisational Management as at 9 September 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 9 September 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 low risk.

Safe and Appropriate Environment as at 9 September 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 9 September 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 9 September 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:	St Josephs Home of Compassion Heretaunga Limited
Certificate name:	St Josephs Home of Compassion Heretaunga Limited

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Surveillance Audit
Premises audited:	St Josephs Home of Compassion
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (including dementia care)
Dates of audit:	**Start date:** 9 September 2014 **End date:** 9 September 2014

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit:	75

Audit Team

Lead Auditor	XXXXX	**Hours on site**	7	**Hours off site**	5

Other Auditors	XXXXXXX	**Total hours on site**	7	**Total hours off site**	5
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXXX			**Hours**	2

Sample Totals

Total audit hours on site	14	Total audit hours off site	12	Total audit hours	26

Number of residents interviewed	4	Number of staff interviewed	9	Number of managers interviewed	2
Number of residents' records reviewed	6	Number of staff records reviewed	6	Total number of managers (headcount)	2
Number of medication records reviewed	12	Total number of staff (headcount)	95	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	3			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 Thursday, 2 October 2014

Executive Summary of Audit

General Overview

St Josephs Home of Compassion Heretaunga provide rest home, hospital and dementia care for up to 78 residents. The total bed numbers include two designated respite care beds. There were 75 residents at the facility on the day of audit (13 rest home, 46 hospital and 16 dementia care).

The service is managed by an experienced aged care manager who is supported by an assistant manager. Both are registered nurses. There is a clinical leader on seven days a week and 24/7 registered nurses. The residents and family/whanau comment positively on the services received.

The one shortfall identified at the previous audit around medication administration has been addressed. This audit identified further improvements required around weight loss monitoring.

Outcome 1.1: Consumer Rights

The service has an open disclosure policy, a complaints policy and an incident/accident reporting policy. Residents and families are kept informed. The resident information pack includes but is not limited to information relating to the Code of Health and Disability Consumers' Rights. Service providers wear uniforms and name tags to identify themselves to the clients.

The service has a complaints policy in place and clients and their family/whanau are provided with information on the complaints process on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints/compliments folder is maintained with all documentation.

Outcome 1.2: Organisational Management

St Joseph's has a five-year strategic plan outlining the direction for the service. The quality framework is implemented and ensures a centralised process is adopted to collate and monitor resident outcomes. The service is responsive to trends and to changes in resident needs. There is an internal audit schedule in place that is being implemented.

Resident incidents, accidents and near misses are recorded on the form for incidents and accidents, safety and hazards and an RN assessment is undertaken at the time to ensure resident safety. Incidents are collated and data/trends are discussed. Where trends are identified, further analysis is undertaken to support change.

Professional qualifications are verified at the time of employment and a record is kept on individual staff files. All staff files reviewed had signed employment contract, job descriptions and completed orientation checklists. The orientation programme is specific to worker type. Annual performance appraisals are current. A comprehensive annual in-service education programme is in place.

There is a staffing policy to guide rostering and staff replacement. The service is managed by a full time manager (RN) and full time assistant manager (RN). Fifteen registered nurses are employed by the service. There are sufficient caregivers hours rostered to provide care requirements. Physiotherapy services are provided for four hours per week.

Outcome 1.3: Continuum of Service Delivery

Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools are in place for residents and evaluated at least six monthly or earlier if required due to changes in health status. InterRAI assessments have commenced. Long term care plans are current and up to date. Families/whanau and residents participate in the care planning process. The use of assessment tools, currency of long term care plans and evaluations occur within the required timeframe. There is an improvement required around weight monitoring.

The recreational co-ordinators provide an integrated rest home and hospital programme and a separate activity programme for the residents in the dementia care unit. The programme meets the recreational needs of the residents. Activity plans include goals and are evaluated at least six monthly at the time of the long term care plan evaluation. Residents in the dementia care unit have individual 24 hour activity programmes. Activity resources are readily available to staff and residents.

There is a robust medication management system with policies and processes that align with accepted guidelines and medication legislation. Registered nurses and caregivers administering medications complete annual medication competencies and medication education. Medication charts are reviewed by the GP three monthly. The previous shortfall around medicine management has been addressed.

Meals are prepared on site. There is dietitian review of the menu plan and individual and special resident dietary needs are accommodated. All hot foods, fridge/freezer temperatures are recorded.

Outcome 1.4: Safe and Appropriate Environment

A current Building Warrant of Fitness is in place that expires 28 February 2015. St Josephs Home of Compassion building is divided into rest home and hospital wings and has a secure dementia unit with safe outdoor access. There is a reactive and planned maintenance programme. There are spacious grounds, seating and shaded areas with safe access to all internal and external communal areas.

Outcome 2: Restraint Minimisation and Safe Practice

The restraint policy includes the definition for the use of enablers. During this audit there was one resident using an enabler (bed rails) and two residents using a restraint. Staff are required to attend training on restraint minimisation every year. This includes completing an annual competency questionnaire.

Outcome 3: Infection Prevention and Control

Surveillance data including types of infections, trends, corrective actions and quality initiatives are reported to relevant committees and staff meetings. Internal infection control education, audits and competencies including hand hygiene are completed. The service infection control surveillance stats are submitted to an external benchmarking organisation for quarterly benchmarking.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	15	0	1	0	0	0
Criteria	0	38	0	1	0	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	62

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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 Low			
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 Low	One resident in the dementia unit has lost 4kg in one month. The kitchen copy of the diet requirements has been updated to include protein drinks. There is no documented interventions or monitoring in place to acknowledges, manage and monitor the weight loss.	Ensure weight loss is documented and monitored.	60

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: FA

Evidence:

St Joseph's has an open disclosure policy which is being implemented.

Staff interviews (four caregivers, one registered nurse (RNs), two clinical leaders (RNs)) confirm residents and family are kept informed. Examples provided include following an adverse event, if there are changes in the resident's condition and following the resident's visit with the GP. FISH (Form for Incidents & Accidents, Safety & Hazards) forms include a section to indicate if family were informed. All eight F.I.S.H forms reviewed indicated family were notified following the incident. The manager acknowledges that effective communication with families and residents is paramount in the day-to-day running of the business. She has an open door policy and welcomes feedback from residents and families. Three-monthly residents' meetings and three-monthly meetings with families are in place (meeting minutes sighted). Interviews with four of four relatives (three hospital-level and one dementia level) and four of four residents (three hospital level and one rest home level) confirm that they are kept informed.

Staff are aware that interpreter services are available if needed. Interpreter services can be accessed through Hutt Valley District Health Board (HVDHB) if needed.

12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.

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 and these are discussed fully with families so they understand.

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: 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 1.1.9.4 (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 complaints, compliments and suggestions policy outlines the process for managing complaints and complies with Right 10 of The Code of Health and Disability Consumers' Rights. Feedback forms are available at the entrance to the facility. Interviews with all four caregivers, one RN, two clinical leaders, the manager and the assistant manager confirm their understanding of the complaints process. Mechanisms are in place to feedback on issues raised through complaints such as resident and family meetings and staff meetings.

A complaints register is in place. There were four lodged complaints for 2013 and three complaints lodged for 2014 (year-to-date). Information relating to each complaint is held in the complaints register. All seven complaints were reviewed and reflect a timely investigation. All seven complaints lodged in the complaints register have been closed.

One complaint by a relative was lodged with the Health and Disability Commissioner's Office on 27 February 2013. The complaint related to the care the resident was receiving. The manager kept the HVDHB and Ministry of Health informed throughout the investigation. The complaint was closed by HDC on 17 May 2013 and not investigated.

Interviews with four families (three hospital level and one dementia level) and four residents (three hospital level and one rest home level) confirm their understanding of the complaints process.

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 Joseph's has a five-year strategic plan outlining the direction for the service.

The manager completes a board report every two months, updating the board on key areas of activity. This includes (but is not limited to): internal audit results, complaints, quality improvement activities, infection surveillance and financials. There is a quality improvement plan for 2014 that focuses on implementing a programme of continuous quality improvement. There are two committees – a quality committee and clinical care committee - that meet alternative months and review progress against the quality plan (minutes sighted).

On the day of audit there were: 13 (of 13) rest home residents, 46 (of 48) hospital residents and 16 (of 16) residents in St John Vianney (the secure dementia unit). One of the resident's in the hospital was in for respite care.

St Joseph's is managed by a (RN) manager with the support of an assistant manager (RN). The manager has been in her role for 13 years. She holds post graduate certificates in health service management and palliative care. The assistant manager was previously one of the clinical leaders. There are two clinical leaders who work across seven days.

The manager has maintained more than eight hours annually of professional development relating to the management of an aged care service.

E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

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 Joseph's has a quality improvement plan for 2014. The quality committee (QC) meet bimonthly (minutes sighted). Discussions include standard agenda items including: infection control, trending from FISH reporting, internal audit results, policy reviews and updates, health and safety and restraint. On the alternate months the clinical care committee (CCC) meet and essentially capture the same range of topics with the inclusion of clinically focused issues such as short term care planning, and topics for handover discussions. Relevant information from the clinical care committee is taken to the quality committee. Outcomes from audits, health and safety, education and policy is disseminated to staff through the various meetings and/or placed on the notice board in the staff room.

RN/EN meetings occur two monthly (minutes sighted). Actions from these meetings are fed into the clinical care and quality committees. There are a number of other meetings including: multidisciplinary resident review meetings (monthly), resident and family meetings (separate meetings, three- monthly), staff meetings (two-monthly) and recreation meetings.

Interviews with four of four caregivers, one of one RN, two of two clinical leaders, the assistant manager and the manager confirm the quality system is understood throughout the service.

Policy manuals include clinical, infection control, human resources and food services. Policies are current and are reviewed on a two yearly cycle - or more frequently if best practice determines. Policy review is managed via the quality and clinical care committees. Updates and new policies are taken to staff via the handover talks. The internal audit programme monitors compliance.

Infection control is discussed as part of the QC and CCC meetings and included on the annual audit schedule. There is a dedicated infection control nurse who is a member of both the CCC and the QC.

A restraint register is maintained, restraint use is monitored and there is a dedicated restraint coordinator. Restraint reviews are incorporated into the QC and CCC.

The service participates in the QPS benchmarking system. The service demonstrates information flows up and down via the QC and CCC with outcomes being reported bimonthly to the board.

The quality framework is implemented and ensures a centralised process is adopted to collate and monitor resident outcomes. The service is responsive to trends and to changes in resident needs. There is an internal audit schedule in place that is being implemented. This is in addition to the data collection linked to the QPS benchmarking programme. Internal audits were reviewed for 2014 (year-to-date). A range of audits are undertaken including: restraints, wounds, code of rights, informed consent and file audit. Where findings determine opportunities for improvements, corrective action plans are generated, implemented and evidenced when closed out. Corrective action plans are also developed where trending is noted from F.I.S.H forms.

A health and safety plan is in place. Environmental inspections are undertaken and findings are seen to be addressed and signed out when complete. Staff interviews confirm the process for reporting an accident. Incident trending and analysis is reported through the CCC with a number of clinical indicators being reported through to the board: (eg, bruising, challenging behaviour, falls). Current hazards are identified and seen in the relevant areas within the facility.

The facility is currently undergoing construction of a new wing. Thirteen residents' rooms will be replaced with 23 rooms. The designation of these rooms is yet to be determined. The manager reports that she meets with the foreman regularly to discuss any building issues or concerns. An accident and incident process is in place. To date, two incidents have been recorded resulting from fire alarms mistakenly being set off. A six-weekly internal audit of the building site ensures that hazards are eliminated, isolated or minimised.

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 - analysis of data has been undertaken and a checklist introduced as a tool for staff to consider potential reasons for resident falls.

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:

Resident incidents, accidents and near misses are recorded on the F.I.S.H form (form for incidents and accidents, safety and hazards) and an RN assessment is undertaken at the time to ensure resident safety, evidenced in reviewing 20 F.I.S.H. forms during July/August 2014. The F.I.S.H form is then forwarded to

the clinical leader for investigation. Incidents (including near misses) are collated and data/trends are discussed at the CCC held every two months. Where trends are identified, further analysis is undertaken to support change. St Joseph's is part of the QPS benchmarking programme which includes key clinical indicators such as skin tears and falls. The manager states that she only benchmarks data where improvements are indicated. Staff are aware of the reporting process. Feedback on trending is available in the staff room.

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.

The manager is aware of required statutory reporting requirements and has policies to support practice. DHB notification occurred with the recent norovirus in July 2014.

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:

Professional qualifications are verified at the time of employment and a record is kept on individual staff files. This includes sighting current practising certificates for the RN's, physiotherapists, GP's, occupational therapist, pharmacy, and podiatrist. Copies are held in staff files.

Six staff files were randomly selected for review. This included one clinical leader, four caregivers, and one registered nurse. Six of six staff files had signed employment contracts and job descriptions. Annual performance appraisals are current.

St Joseph's has an orientation programme in place that provides new staff with relevant information for safe work practice - such as mission, individual role, policies, medication (if required), fire, occupational health, manual handling, infection control. The orientation programme is specific to worker type. In all six staff files reviewed there was evidence of completed and signed orientation checklists. New caregiver staff are buddied for up to two weeks with a senior staff member. Four of four caregivers were able to describe the orientation process and stated that new staff were adequately orientated to the service.

E4.5d: The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

E4.5e: Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.

St Joseph's has RN educators who are assessors for the Aged Care Education (ACE) programme. A comprehensive annual in-service education programme is in place. Four of four caregivers report that the education that is provided is a key strength of the service. External education is also available to staff including education and training through HVDHB and palliative care (hospice) services. The education schedule exceeds eight hours annually. Topics are held multiple times to ensure all staff attend. For example, during the audit a restraint education and training course was being held for the third time in 2014. When staff attend an in-service a record is made against their employee record.

The caregivers, RN's and recreation officers who work in the dementia unit have completed their ACE dementia standard.

St Joseph's runs handover talks that include topics such as pressure area care, indwelling catheters, communication and restraint. These sessions are approximately 15 minutes duration and are undertaken at each handover covering all service areas.

St Joseph’s staff are also required to attend annual compulsory training offered over a three-hour period that includes the following topics: restraint, code of rights, fire, health and safety, civil defence, elder abuse, cultural safety and complaints process. There are four annual competencies - hoists, code of rights, restraint, and medications.

E4.5f: Caregivers must complete the ACE dementia standard before they are allowed to work in the dementia unit. They are allowed six months to complete this standard. The manager reports that the RNs also complete the ACE dementia standard. There is one RN who has been employed for less than six months who is just finishing her ACE dementia standard. All other staff working in the secure dementia unit have completed the dementia standard.

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:

There is a staffing policy to guide rostering and staff replacement. The policy notes staffing requirements are influenced by client dependency and there is capacity for the shift RN to increase staffing numbers based on acuity. The service is managed by a full time manager (RN) and full time assistant manager (RN).

Fifteen registered nurses are employed by the service. Two RNs are scheduled for the AM and PM shift (one RN covers the hospital and rest home and the second RN covers the hospital and dementia unit). One RN is scheduled for the night shift. In addition, there are two full-time clinical leader (RN) positions that cover the facility seven days a week during the AM shift to provide support and leadership for the RN workforce.

There are sufficient caregivers hours rostered to provide care requirements as well as a cook, kitchen hands, cleaners, maintenance, and activities staff. Physiotherapy services are provided for four hours per week.

Interviews with four of four caregivers and two of two RN's indicate staffing levels are sufficient to meet the needs of the 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:

There is a policy and process that describe resident's assessment and review procedures.
D16.2, 3, 4: A registered nurse undertakes the assessments on admission, with the initial care plan completed within 24 hours of admission. Within three weeks the long term care plan is developed in the five of six files resident files sampled (two hospital, two rest home, two dementia). In six of six resident files sampled the initial admission assessment and care plan summary is completed and signed off by a registered nurse. The resident assessment is carried out on admission and reviewed six monthly or earlier if resident health status changes. There is evidence of resident and/or family/whanau/EPOA involvement in the care planning and review process. Activity assessments and the activities care plans have been completed by the recreational co-ordinator.
Care plans are used by nursing staff and caregivers to ensure care delivery is in line with the residents assessed needs.
There is a verbal and written daily handover forms for caregivers and registered nurses at the beginning of each shift and any resident concerns or events are communicated to the oncoming staff. Four caregivers, one registered nurses and two clinical leaders could describe a verbal handover at the start of each duty that maintains a continuity of service delivery. Progress notes are maintained.
All six files identified integration of allied health including general practitioner, GP, physiotherapist, consultant psychiatrist, older person mental health service, mental health community support nurse and podiatrist.
Medical assessments are completed within 48 hours of admission by the GP in six of six resident files sampled. The GP (interviewed) is one of two GPs contracted to provide medical services. They visit twice weekly on Tuesdays and Fridays. The GPs carry out routine three monthly visits and see any residents of concern. The GPs cover for each other's patients that require a visit during the week. The GP is available 24/7 and in the weekends. Families are encouraged to meet with the GPs and are invited to the three monthly reviews. The GPs provide support and advice to the RN team. The pharmacist input at the multidisciplinary reviews is appreciated by the GPs. The GPs are positive about the care their patients receive and the physiotherapy service provided at the facility. There is a physiotherapist contracted for four hours per week who completes physiotherapy assessments, equipment assessments, post falls assessments and exercise programs.

Two dementia care resident files sampled are as follows;

Tracer methodology dementia care;

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

Tracer methodology; Hospital resident

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

Two rest home resident files

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 Low

Evidence:

St Josephs Home of Compassion provides services for residents requiring rest home, hospital and dementia level of care. The care being provided is consistent with the needs of residents, this is evidenced through interviews with four caregivers, one registered nurses, four family/whanau (three hospital, one dementia care) and four residents (three hospital, one rest home). Residents' long term care plans are completed by the registered nurse. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. There is documented evidence on the family/whanau record sheet held in the resident's files of family notification for resident's health changes, GP visits, incidents and infections. The three residents and two family/whanau members, interviewed are complimentary of care received at the facility.

D18.3 and 4 Dressing supplies are available and a room is stocked for use. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit plentiful supplies of these products are sighted. 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.
There are currently six skin tears, five minor wounds and two residents with pressure areas of heels at the facility. All of the skin tears, wounds and pressure areas have a wound assessment, treatment chart and evaluations completed as per the frequency required. The size of wounds are monitored. Short term care plans are in place for all wounds. An ulcer monitoring system identifies pressure area resources required. Pressure area interventions are documented on the care plan.

A range of assessment tools completed on admission are evident in the six resident files sampled and completed at least six monthly including (but not limited to); a) dietary requirements b) waterlow pressure area risk assessment, c) continence assessment d) falls risk assessment e) wound assessment g)

physiotherapy assessment h) wound assessment and i) verbalising and non-verbalising pain assessments. Monitoring forms include behaviour monitoring, weight monitoring, blood pressure and pulse monitoring. There is an improvement required around weight monitoring.

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 Low

Evidence:

A range of assessment tools completed on admission are evident in the six resident files sampled and completed at least six monthly including (but not limited to); a) dietary requirements b) waterlow pressure area risk assessment, c) continence assessment, d) falls risk assessment, e) wound assessment, g) physiotherapy assessment, h) wound assessment, and i) verbalising and non-verbalising pain assessments. Monitoring forms include behaviour monitoring, weight monitoring, blood pressure and pulse monitoring.

Finding:

One resident in the dementia unit has lost 4kg in one month. The kitchen copy of the diet requirements has been updated to include protein drinks. There is no documented interventions or monitoring in place to acknowledges, manage and monitor the weight loss.

Corrective Action:

Ensure weight loss is documented and monitored.

Timeframe (days): 60 *(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 three recreation co-ordinators who are employed for a total of 62 hours per week Monday to Friday to deliver the integrated rest home/hospital programme and a separate programme for the dementia unit. The senior recreation co-ordinator has completed core competencies, dementia course and has commenced diversional therapy (DT) training. All the recreation co-ordinators have a current first aid certificate. The recreation co-ordinators attend the regional DT group meetings and workshops/training. There is a group of volunteers who visits residents daily and assist with board games, bowls, crafts, baking, one on one resident time (discussions, reminiscing etc.). There is musical entertainment and pet therapy visits scheduled for Saturdays.

The service provides a comprehensive activity plan that meets the needs and functional capabilities of the consumer groups. There are large dining areas and several smaller lounges and seating alcoves where entertainment and small group and individual activities can take place. Dementia care residents are

able to attend rest home/hospital activities and entertainment under supervision. Rest home/hospital activities include (but not limited to); news, exercises (sit/dance/balloon and musical exercises), games, quizzes, scrabble, baking, crafts, bowls, scrabble, cards and reminiscence. A musical therapist is employed one morning a week and a music therapy student from the university works with the music listening group four days a week. Activities in the dementia unit include (but not limited to); household tasks, reminiscence, reading, music therapy, exercises, bowls, walks outside, poetry, reflective time, sing-a-longs and dance. An interactive sing-a-long with dance and ice-creams observed in the dementia unit involved two recreation co-ordinators, care staff and residents. Each dementia care resident has an individual 24 hour activity programme. The recreation co-ordinator (interviewed) states resources are readily available. Community links are maintained with the men's group attending the working men's club, residents attending the annual community concert and St James musical afternoons. There is a knitters group that knit items for premature babies. The service has a chapel for interdenominational church services, monthly Anglican services and daily Mass.

The Salvation Army church members visit residents regularly. One of the volunteers is the resident advocate and attends the resident meetings. Van outings are at least weekly for the residents in the rest home/hospital and dementia care unit. The four residents interviewed (three hospital, one rest home) and four family/whanau members interviewed (three hospital and one dementia) reported satisfaction with the variety of activities, entertainment and outings offered. An individual activity assessment is completed for each resident on admission. A recreation plan is developed in consultation with the resident/family within four weeks of admission and is reviewed at least six monthly or earlier if required. The recreational co-ordinators are included in the MDT reviews.

D16.5d: Resident files reviewed identified that the individual activity plan is reviewed at 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:

There are six monthly written resident reviews which involve the RN, GP, resident/family as appropriate, recreation co-ordinator, physiotherapist, pharmacist, pastoral care and massage therapist as applicable. Short term care plans are available for use for short term needs with nursing problems resolved or if an on-going problem transferred to the long term care plan. Short term care plans sighted in resident files are for chest infection, skin tears, and cellulitis and pressure area of toes (resolved). A review of five of six files identified that all five long term care plans have been evaluated six monthly or more frequently if the residents needs have changed. One dementia care resident has not been at the service long enough for a six monthly evaluation.

D16.4a: Care plans are evaluated six monthly more frequently when clinically indicated by the RN. Short term care plans are evaluated regularly.
D16.3c: All initial care plans of six files sampled were evaluated 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: FA

Evidence:

All medications trolleys are stored safely in the rest home, hospital and dementia unit locked medication rooms. The supplying pharmacy delivers the regular and prn medications in robotic rolls. RNs check all medications against the medication chart on delivery to the facility and sign off on the pharmacy order form. Any discrepancies are fed back to the pharmacy or prescriber. All medications in trolleys are within the expiry date and eye drops dated on opening. All oral, topical and prn medications are prescribed for named residents (sighted in trolleys and medication cupboards). This is an improvement since the previous audit. The controlled drug safe and controlled drugs are kept in the hospital unit medication room. Controlled drugs are checked weekly. RNs only administer controlled drugs. There is a hospital stock of medications and antibiotic supply held for GP use in the hospital unit medication room. The medication fridge has daily temperatures recorded (sighted). RNs and caregivers (rest home and dementia unit) administer medications and complete an annual medication competency for oral administration of medications, controlled drugs and insulin. RNs have syringe driver competency. Standing orders are current. There are currently no self-medicating residents. Oxygen and suction is available. Sharps are disposed of into an approved sharps container.

Signing sheets for 12 residents are sampled. There are no signing gaps. PRN medications administered are dated and timed. RNs are required to authorise the administration of prn medications.

All 12 medication charts sampled (four hospital, four rest home and four dementia) have photograph identification and allergies documented. Medication charts are pharmacy generated.

D16.5.e.i.2; Twelve medication charts reviewed identified that the GP had seen and reviewed the resident at least 3 monthly and the medication chart was signed.

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: 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 1.3.13: 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:

There is a food services manual that ensures that all stages of food delivery to the resident is documented and complies with current standards.

All food is cooked on site. There is a qualified cook on duty daily from 7am-1.30pm. The cook is supported by a morning kitchen hand and an afternoon kitchen hand. The cook follows a six weekly menu which is currently being reviewed by a dietitian. The cook receives diet sheets for each new resident and notified of any resident dietary changes. The kitchen maintain a list of resident likes and dislikes. Alternative meal options are provided. Special diets catered for include; gluten free, low fat and low salt. Normal soft and pureed meals are provided as per the resident's diet sheet. The cook (interviewed) could describe dietary interventions for residents with weight loss. Meals are transported in bain maries to the unit kitchenettes where caregivers serve the meals. Lip plates and special utensils are available for residents to promote independence at meal times. Hot food temperatures are taken and recorded on the main midday meal and evening meal. Fridge and freezer temperatures are checked and recorded daily. All facility fridges are monitored daily (records sighted). The kitchen has a good work flow with delivery, storage, meal preparation, baking, and dishwashing areas. Dry goods are dated and in sealed containers. The pantry is tidy with all foods in sealed and labelled containers and off the floor. All foods in the chiller, freezers and fridges are dated. Staff are observed wearing appropriate protective clothing. Chemicals are stored in a locked area when not in use. The cook receives feedback on the service directly, through resident meetings, staff meetings and surveys. Residents interviewed state they enjoy the meals and home baking.
D19.2 Staff have completed training in safe food handling.

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:

A current Building Warrant of Fitness is in place that expires 28 February 2015. St Josephs Home of Compassion building is divided into rest home and hospital wings and has a separate dementia secure unit. There is a reactive and planned maintenance programme. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated July 2014. Hot water temperature monitoring in resident areas are stable at 43-45 degrees Celsius. There are spacious grounds, seating and shaded areas with free access to all internal and external communal areas.

ARC D15.3; The four caregivers and three registered nurses interviewed state that they have all the equipment referred to in care plans and necessary to provide care, including wheelchairs, continence supplies, dressing supplies, hoists, chair scales (calibrated July 2014) , electric and ultra-low beds, sensor mats, landing pads, gloves, and any miscellaneous items.

E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities. E3.3e; There are quiet, low stimulus areas that provide privacy when required.
E3.3e: E3.4.c; There is a safe and secure outside area that is easy to access for dementia residents.

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.)*

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:

The restraint policy includes the definition for the use of enablers. During this audit there was one resident using an enabler (bed rails) and two residents using a restraint. The assessment process is the same for restraints and enablers.

The file of the resident using an enabler was selected for review. A full restraint/enabler assessment was completed and there was evidence of signed consent by the resident for the use of the enabler. The use of the enabler is reviewed every six months.

Staff are required to attend training on restraint minimisation every year. This includes completing an annual competency questionnaire.

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:

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator)IC) (RN/clinical leader) has been in the role for three years and has a job description that defines the role and responsibilities. The IC co-ordinator uses the information obtained through surveillance to plan and determine infection control activities, resources and education needs within the facility. Resident infections are reported to the RN or IC co-ordinator who assesses the resident and commences a short term care plan. Infections are collated monthly with trends identified, implementation of corrective actions and opportunities for improvement identified. Surveillance methods include daily physical rounds of the environment and residents, GP visits and laboratory reports. The IC co-ordinator provides a monthly report to the quality meetings. RNs and caregivers interviewed confirm they receive information on infections, C stats and graphs. The IC co-ordinator has access to external IC specialists such as DHB infection nurses, internet resources, NZNO. The IC co-ordinator has attended external training on outbreak management. The staff received education in June 2014 and complete infection control competencies. The service participate in QPS benchmarking quarterly. The service had an outbreak of norovirus July 2014. There were adequate supplies and resources available to manage the outbreak.

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.)*