

# Little Sisters of The Poor Aged Care New Zealand Limited - St Joseph's

---

## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Little Sisters of The Poor Aged Care New Zealand Limited
<b>Premises audited:</b>	St Joseph's Home & Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 12 November 2014    End date: 12 November 2014
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	30

--

# Executive summary of the audit

---

## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	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
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

St Joseph's Home and Hospital is a purpose built facility and is part of a larger aged care complex. The service provides care for up to 31 rest home and hospital residents. The current occupancy is 30 residents, two rest home and 28 hospital residents.

The service is managed by the Little Sisters of the Poor, which is a charitable organisation run by an 'order of nuns'. The facility manager is a registered nurse and she has been in the role since April 2014. She has extensive experience managing other 'Little Sisters of the Poor' aged care facilities. She is supported by a nurse manager and a stable workforce.

The facility has a current business plan that includes goals, quality improvement and risk management and the mechanism for monitoring progress. The plan is being implemented. All residents and relatives interviewed spoke very highly about the care and support provided by staff and management.

The service has addressed all four shortfalls from the previous certification audit around job descriptions for volunteer helpers, annual appraisals, medication transcribing and restraint documentation.

This audit has identified improvements required around wound care documentation and aspects of medication.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
--	--	--

The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. The complaints process and forms for completion are available in the reception area. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout the facility.

## Organisational management

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

The service has an established quality and risk management system that supports the provision of clinical care. A monthly quality focus meeting includes a monthly review of services and measurement against stated goals. Key components of the quality management system including management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections through the surveillance programme, review of risk and monitoring of health and safety including hazards and maintenance. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents, family and staff state that there are sufficient staff on duty at all times. There is an implemented orientation programme

that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support. An active volunteer programme is in place

## Continuum of service delivery

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

Registered nurses are responsible for each stage of service provision. Care plans are developed in InterRAI and hard copy and demonstrate service integration and guide staff in care. Care plans are reviewed six monthly or when there are changes in health status. Resident files include notes from the general practitioner and allied health professionals. There is an improvement required around documenting review dates on all wound charts.

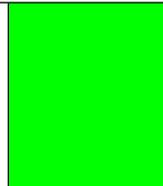
There are policies that describe medication management that reflect legislative requirements. Education and medicines competencies are completed by the registered nurses. The medicine records reviewed include documentation of allergies and sensitivities and these are highlighted. There is an improvement required around caregivers signing for controlled drugs without having any training.

The activities are facilitated by an activities assistant who has occupational therapy training. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged and van outings occur.

All food is cooked on site by the cook. All residents' needs are identified, documented and choices are available and provided. Meals are well presented, homely and the menu plans have been reviewed by a dietician.

## Safe and appropriate environment

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

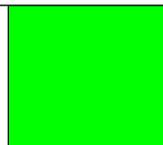


Standards applicable to this service fully attained.

There is a current building warrant of fitness that expires 8 August 2015.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

There is a restraint minimisation and safe practice 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 an enabler's register. There is one resident requiring restraint and four residents with identified enablers. All enabler use is voluntary.

## Infection prevention and control

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.

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to quality and staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	14	0	1	1	0	0
<b>Criteria</b>	0	37	0	1	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>A complaints process is in place. The complaints procedure is provided to residents and relatives at entry both in writing and verbally (evidenced in interviews with the facility manager, nurse manager and two registered nurses). Documentation relating to complaints is held in the complaints folder, and recorded on the complaints register. Ten complaints were lodged in 2013 which have all been documented as resolved. There are five written complaints to date in 2014. All five complaints were selected for review. In each instance, appropriate follow-up action had been taken and was documented.</p> <p>Discussions with five residents (one rest home and four hospital) and three family/whanau (one rest home and two hospital)) confirm they are provided with information on complaints and understand the complaints process.</p> <p>D13.3h: A complaints procedure is provided to residents with the information pack at entry.</p> <p>Interviews with four of four caregivers and two of two registered nurses, five residents and three families confirms their understanding of the complaints process.</p> <p>D13.3h. a complaints procedure is provided to residents within the information pack at entry</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Accident, incidents, complaints and the open disclosure policy alert staff to their responsibility to notify family/next of kin of any adverse event that occurs. A specific policy to guide staff on the process to ensure full and frank open disclosure is available.</p> <p>Accident/incident forms have a section to indicate if family/whanau have been informed (or not) of an accident/incident. Five of five incident forms reviewed identified that family were notified.</p> <p>Families frequently give instructions to staff regarding what they would like to be contacted about and when they wish to be contacted should an accident/incident of a certain type occur. This is documented in the resident files (evidenced in five of five files reviewed). In the front of each file, there is record of family contact.</p> <p>An interpreter policy is in place. Interpreter services are available and information is clearly displayed. At present there are no residents where English is their second language. The organisation has multilingual staff that can provide interpreter services. If necessary, interpreter services can be accessed through ADHB. The service produces a monthly newsletter "The Grapevine".</p> <p>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.</p> <p>D16.1b.ii: 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.</p> <p>D16.4b: Three of three relatives/whanau (one rest home and two hospital)) report they are kept informed when their family member's health status changes.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The organisation has a strategic plan for 2014/15 with a clear purpose, values, scope, direction and goals. A provincial governing board monitors the organisation in New Zealand and the overall structure of the facility. The Mother Superior reports to the Mother Provincial for the province of Oceania and meets with the governing board six monthly.</p> <p>The service can provide care for up to 31 residents with 31 rooms certified as dual purpose beds (rest home and hospital level care). During the audit the facility had 30 residents, two rest home residents and 28 hospital residents.</p> <p>The Mother Superior is responsible for the overall management of the facility. She is a registered nurse and has been at the service since April 2014 (has previously managed the service). The Mother Superior has held various nursing and management roles in hospitals and aged care facilities for many years. She has attended the following training in 2014: government management training,</p>

		<p>management of homes through the organisation, falls and pressure care, safe handling and medications, privacy training and is scheduled to attend the four quadrant leadership training in November 2014. The Mother Superior is supported by a nurse manager who has also attended more than eight hours of professional development during 2013/14 including InterRAI training.</p> <p>ARC,D17.3di (rest home), D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The service has a 2014/15 strategic business and risk management plan. The service has a philosophy, a mission and core values of the service include, care, respect and palliative care. The key objectives for the service include a focus on quality care, review of policies and procedures (reviewed two yearly), clinical care constantly under review, to embrace the Liverpool Care Pathway and to introduce a new programme for volunteers that sets boundaries for health and safety. The service has also completed previous objectives including replacing the computer system, changing the plumbing system, replacing the carpets and tiles ad complete the InterRAI training.</p> <p>The organisation has a quality systems and management policy in place. The quality programme is understood by staff (evidenced in interviews with four caregivers, two registered nurses, a cook, and two activities assistants).</p> <p>A select group of staff participate in the internal audit programme. The registered nurses monitor the effectiveness of the infection control programme, health and safety systems and restraint monitoring.</p> <p>Policies are in place for all aspects of service delivery. All policies are subject to a two yearly review, evidenced in the footer section of each policy. Policies are readily available to staff in hard copy. Electronic (PDF) versions of policies are also available. Policies are up-to-date and are linked to the Health and Disability Sector Standard (HDSS), current and applicable legislation, and evidenced-based best practice guidelines.</p> <p>A document management process controls policies and procedures. The review process is overseen by the nurse manager with external support provided by the ADHB gerontology nurse specialists. New policies are discussed in applicable meetings (meeting minutes sighted for focus meetings, staff meetings, health and safety meetings, nursing meetings).</p> <p>Service delivery is monitored through incident and accident reporting, complaints management, infection control monitoring, health and safety compliance, restraint monitoring, residents meetings three monthly (10 November 2014) and the annual resident satisfaction survey ( August 2014) which resulted in overall satisfaction and recommendation of the service to others.</p> <p>Data is collected monthly for infection rates, incidents and accidents, skin integrity, medication errors</p>

		<p>and behaviour with results provided to staff. Restraint use is monitored by the restraint coordinator.</p> <p>The robust internal audit programme monitors key aspects of the service. Audits completed in 2014 include but not limited to: resident's files, privacy information, resident hygiene, food service, safety/restraint, behavioural management, resident's rights, medication, food storage, and care of equipment. There is a focus group meeting monthly that includes all senior staff that discuss the following: financials, nursing, kitchen, HR, education, maintenance, health and safety, quality audit results and corrective actions, policy review, food service and any other facility updates (minutes sighted 15 October 2014). All quality data and audit result following the focus meeting are provided to staff with evidence of discussions relating to the corrective actions (monthly staff meetings October 2014, health and safety meetings August 2014, monthly nursing meetings September 2014, quarterly restraint minimisation meetings November 2014, monthly catering meetings and monthly meetings with Spotless (contracted cleaning company) sighted September 2014. There is a summary of results presented for each audit that is discussed at staff handovers and a copy is displayed in the staff room. Copies of the minutes of meetings are available in the staff room.</p> <p>Achievements against the quality and risk management plan are highlighted. A recent quality initiative has been a programme for staff, delivered by an external educator, on looking at what staff wanted to do to improve the service to residents. As a result of the meeting the service has been monitoring food waste and intends to collate the information to review with all staff and make changes if required to the food service. This programme is ongoing. Corrective action plans are developed and documented, dependant where opportunities for improvements are identified.</p> <p>All staff interviewed (caregivers, RNs, activities, cook) report they are involved in the development of quality initiatives and are kept informed of quality improvements and corrective action plans.</p> <p>A risk management plan is in place that documents risks associated with the service, along with minimisation strategies. The hazard register identifies hazards. All identified hazards have risk management strategies, such as minimisation, isolation or elimination.</p> <p>D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.</p> <p>D19.2g Falls prevention strategies are in place including the use of sensor mats and physiotherapy assessments for residents at risk.</p>
--	--	--

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The service collects incident and accident data. The incident/accident form provides an account of the incident; what actions were taken in response; who and when people were informed; any detail that will assist in determining how the incident occurred; and what actions were taken/are required to prevent recurrence.</p> <p>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 service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required.</p> <p>Five incident forms were reviewed across the service and all demonstrated clinical follow-up by a registered nurse. Incidents and accidents are reviewed and followed up by the nurse manager (RN). There is also evidence of an incident form being documented and followed up for each event (evidenced in follow-up of five of five adverse events).</p> <p>A monthly report on incident data is sent to the ADHB as part of the facilities reporting DHB requirements.</p> <p>D19.3c St Joseph's has a reportable event policy. Policy identifies the events that need to be reported, by whom and the process to follow. Discussions with the nurse manager confirm an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>The service has reported a serious harm incident under Section 31 to the ADHB and HealthCERT on 9 September 2014.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Copies of practising certificates were sighted for the registered nurses (10), the enrolled nurse (one), the GP, podiatrist and physiotherapist. Current copies of practising certificates are held on file.</p> <p>Five staff files were randomly selected for review (one registered nurse, two caregivers, one activities coordinator and one cook). Qualifications of applicants are validated and two reference checks are completed prior to appointment. Annual performance appraisals are up to date in all five files reviewed. This was a previous audit finding that has now been addressed.</p> <p>All staff undergo a comprehensive orientation programme (evidenced in five of five staff files) that meets the educational requirements of the ARC contract.</p> <p>There are approximately 60 volunteers working at the facility. The facility policy determines that all volunteers are required to undergo a police check before beginning their volunteer work. References are checked, and any medical problems are disclosed on the volunteer application form. An orientation</p>

		<p>programme is in place for the volunteers. A volunteer handbook was sighted that includes information relating to residents' rights, fire safety and occupational health and safety (OSH. All volunteers have signed confidentiality agreements (sighted). This was a previous audit finding that has now been addressed.</p> <p>Caregivers are paired with a senior caregiver until they demonstrate competency on a number of tasks including personal cares. Annual medication competencies are completed for all registered and enrolled nurses who administer medications to residents.</p> <p>The organisation has a mandatory education programme with sessions held monthly. There is a two year plan for 2014/15 sighted. Sessions are provided by the registered nurses, the physiotherapist or external presenters such as nurse specialists or the HDC Advocate. They are presented on multiple occasions to improve attendance rates. The service has also introduced core topic days. Core topic days held in January and again in February 2014 included IPC, skin integrity, wound management, pressure injuries, skin tears and diabetes. The core topic day held in September 2014 included abuse and neglect, cultural safety, sexuality and intimacy and harassment prevention. Further education completed in 2014 includes but not limited to chemical safety, restraint management, manual handling, use of hoists, medication management, pain management, privacy and dignity, code of rights, complaints procedure, open disclosure, food safety, nutrition and hydration, fire evacuation, fire emergency and hazard management. There is ongoing "off the floor" training provided applying learnt skills and knowledge for all staff. The education programme is managed by the HR manager.</p> <p>External education is provided for registered nurses and caregiver staff through the Auckland District Health Board (ADHB). Clinical updates are provided by an external consultant and the ADHB. Managers attend aged care conferences.</p> <p>All caregivers undertake the Aged Care Education or Careerforce Education programmes. They are provided with an on-line learning programme (20 modules), developed by an external consultant, that is accompanied by workbooks. Education and training hours exceed eight hours a year.</p> <p>D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to) medication competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or</p>	<p>FA</p>	<p>The work force and skill mix policy is the foundation for work force planning and competence. Staffing levels are reviewed annually for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. It is the mission of the Sisters to sit with palliative care end stage residents. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy.</p> <p>The morning shift is staffed with one RN with two RNs covering two days a week to assist with GP</p>

<p>experienced service providers.</p>		<p>visits. One RN is staffed on the PM shift and one RN is staffed on the night shift.</p> <p>Five caregivers are staffed on the am shift, three on the pm shift and one on the night shift.</p> <p>Three sisters (Mother Superior, the nurse manager and one other sister) are registered nurses and supplement staffing levels as needed. The sisters reside on the premise. The nurse manager is on call and acts as the facility manager when the Mother Superior is absent.</p> <p>Five residents (one rest home and four hospital) and three relatives report staffing levels are adequate to meet their needs / the needs of the residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The service medication management system follows recognised standards and guidelines for safe medicine management practice. The facility uses a weekly supplied pack system. Medications are checked on arrival by the registered nurse.</p> <p>Additional medications required are delivered and recorded as received. There was one pharmacy generated sheet which shows the picture of the drug prescribed.</p> <p>All medications are kept in a locked trolley in a keypad locked room. The medication fridge temperature is checked weekly. All medications in the fridges, drug trollies and shelves were sighted. All eye drops are dated and all PRN (as required) medications have documented indication for use by the GP.</p> <p>Ten resident medication charts were reviewed and all are identified with ID photos and were current. All ten signing sheets were correct and complete.</p> <p>The service has addressed a previous audit finding around transcribing of medications. There is no evidence of transcribing on any of the 10 medication charts reviewed. There is a list of staff with specimen signatures. Registered nurses administer medications and have completed annual medicine competencies. Medication education has been completed.</p> <p>Controlled drugs are stored in a locked safe and a review of the controlled drug register shows all controlled drugs are checked by two people. Caregivers report that they are signing for controlled drugs and do not have any training. This is an area that requires improvement. Weekly controlled drug stock takes have been completed.</p> <p>There are no residents self-medicating. Medication management audits have been completed. One registered nurse was observed safely and correctly administering medications.</p> <p>D16.5.e.i.2; Nine of ten medication charts reviewed identified that the general practitioner had seen the resident three monthly and the medication chart was reviewed and signed (one hospital resident has been at the service less than three months).</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Food is prepared on site in the facility's main kitchen. Food service is an in-house operation. There is one cook and one kitchen hand on duty seven days a week. All four kitchen staff have completed food safety training. The two staff observed in the kitchen were wearing correct protective clothing and safe footwear.</p> <p>There is a six week rotating seasonal menu. The summer menu has just commenced. This rotating menu is checked by an independent dietician consultant.</p> <p>There are two dining rooms and food is transported to these in bain maries. Food served on the day was hot and well presented.</p> <p>Residents are given choices including alternate meat dishes and vegetarian and the staff can cater to specific requests if needed. Diets are modified as required. Special diets are catered for and well documented in the kitchen.</p> <p>A registered nurse completes a nutritional profile on admission and this is reviewed six monthly with care plan review. Residents are encouraged to express their likes and dislikes. Special equipment is available if needed. Residents requiring extra support to eat and drink are assisted, this was observed at lunch. Breakfast is served in the residents' rooms.</p> <p>The kitchen was very clean and tidy. There is a manual detailing all procedures. Fridge and freezer temperature are checked daily. Food in the fridge and freezer was covered and dated. All food is off the floor. Chemicals are locked away. There is electric and gas equipment for cooking</p> <p>Food audits are carried out annually or on a less formal basis day to day or at resident meetings. All three families and five residents interviewed expressed their satisfaction with the food.</p> <p>D19.2 Staff have been trained in safe food handling.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>The facility provides services for residents requiring rest home and hospital level of care. The care being provided is consistent with the needs of residents. The care plans are comprehensively completed. There is a short term care plan that is used for acute or short term changes in health status. Activity assessments and the activities care plans have been completed by the activities assistant. One rest home file and four hospital files were sampled.</p> <p>Continence products are available. Continence assessments include urine and bowel management and continence products are identified for day and night use. Assessments are done six monthly or as necessary. Continence management in-service has been held.</p> <p>D18.3 and 4 Dressing supplies are available and there is a well-stocked treatment room. Wound management in-service has been held. The facility has access to specialist advice if necessary and there was documented evidence that this was used when necessary.</p>

		<p>Wound assessment and wound management plans are in place for 12 wounds reviewed. There were six skin tears and six other wounds including abrasions and ulcers. Eight of the 12 did not have review dates. This is an area that requires improvement. The registered nurses are also using a daily wound chart. There are no pressure areas.</p> <p>The general practitioner interviewed reported confidence with the service and in the registered nurses ability to deal with emergency issues.</p> <p>During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents to the shower or toilet. Residents interviewed were able to confirm that privacy and dignity was maintained.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities assistant is a registered occupational therapist but she does not have a current practising certificate. The activities assistant is assisted by a nun who is a caregiver. When the activities assistant is not working the nun undertakes activities management. Both have considerable experience in the care of the elderly. The activities assistant works 20 hours a week Monday –Friday. They both provide a full, varied and interesting programme seven days a week excluding public holidays. They both attend workshops and support groups. There is a monthly programme developed with the residents. This is displayed on the noticeboards. There is also a weekly programme displayed on the noticeboards and in the weekly newsletter 'The Grapevine'. There was a request for activity suggestions from residents sighted in the weekly 'Grapevine' newsletter. This is provided in enlarged form for those residents who are visually impaired. The residents are notified if there are any changes to the programme. Activities are planned that are appropriate to the functional capabilities of residents. Residents are able to participate in Mass, bingo, exercise programmes eg sit dancing, baking, craft, music, quiz and games. There is also reminiscing.</p> <p>St Josephs has a mini-van so residents can go on outings. There are two outings planned each week, the first is a scenic drive and the second is generally an outing to a place eg the movies or a museum. The assistant on the minivan outings holds a first aid certificate. There are also visits from pets and young people's groups who run sports activities. Once a week a group of volunteers comes in and bakes scones for the residents and they have a communal morning tea and social occasion.</p> <p>The activities assistant described providing regular one on one with those residents that prefer not to attend group activities. Once a week there is hand massage in their own rooms, they may be taken for a walk in the garden and library books can be ordered weekly. There are also music CD's available.</p> <p>There is a range of cultural activities and celebrations. They have an annual ball which is attended by families and staff as well as residents.</p> <p>The facility has a large communal area that has a dance floor area, a stage and a theatre sound</p>

		<p>system. This is used for special events. There is a chapel where services are conducted daily. If residents are unable to attend they can watch a live link of the service through the TV in their bedrooms.</p> <p>Internet access is available in rooms.</p> <p>Residents have an activities plan written with resident and family involvement.</p> <p>Monthly progress notes are written and six monthly evaluation is documented in four of five files reviewed (one hospital resident has been at the service less than six months). The assessment documents a social history and previous interests and the care plan includes goals.</p> <p>Three family members and five residents interviewed all stated that they were very satisfied with the activity programme.</p> <p>D16.5d Resident files reviewed identified that the individual activity plan is reviewed at care plan review.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>There is a three monthly review by the general practitioner which includes resident's medications as evidenced in four of five files sampled (one hospital resident has been at the service less than three months). Care plans are evaluated by the registered nurses six monthly or when there is a change in health status and/or care. There was documented evidence that evaluations were up to date in four files reviewed (one hospital resident has been at the service less than six months). Assessment tools are reviewed three monthly or as necessary. There was documented evidence of this in four files reviewed. The fifth file was a recent admission.</p> <p>D16.4a Care plans are reviewed and evaluated by the registered nurses six monthly or when changes to care occur as sighted in four of five care plans sampled.</p> <p>ARC D16.3c: All initial nursing assessment/care plans were evaluated by an RN within three weeks of admission in four of five files reviewed (one hospital resident has been at the service less than three weeks).</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There is a current building warrant of fitness that expires 8 August 2015.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection monitoring is the responsibility of the IC coordinators. The infection control policy (reviewed January 2014) describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at St Joseph's are appropriate to the acuity, risk and needs of the residents.</p> <p>The IC coordinators enter infections on to the infection register and carry out a monthly analysis of the data. The analysis is reported to all staff meetings (minutes viewed). The IC coordinators use the information obtained through the surveillance of data to determine infection control education needs within the facility</p> <p>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.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a restraint minimisation procedure. This includes definitions of restraints and enablers, cultural safety, privacy and dignity, approved restraints, use of enablers, the role of the restraint coordinator, alternative interventions, implementing restraint, assessing risk, consent, monitoring, evaluation, quality review and education.</p> <p>The restraint coordinator is a registered nurse. The restraint coordinator interviewed was able to clearly describe the minimisation strategies used. There is a restraint committee which meets three monthly or as necessary. Meeting notes were sighted.</p> <p>There is a restraint register. There is also a register for hi-lo beds and anti-roll mattresses.</p> <p>All staff receive education on restraint minimisation at orientation and as part of in-service training.</p> <p>There are currently four enablers and one restraint in use. Four enabler and one restraint file were reviewed. All had signed consents. The restraint had the risks associated with restraint identified and documented on the assessment and consent form. Alternative strategies had been tried before restraint was applied.</p> <p>The service has addressed a previous audit finding ensuring the use of enablers is voluntary and the least restrictive option is used to promote or maintain resident independence and safety.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Moderate	Registered nurses administer medications. Controlled drugs are stored in a locked safe and a review of the controlled drug register shows all controlled drugs are checked by two people.	Caregivers are signing for controlled drugs counts and do not have any training.	<p>Ensure that caregivers have training in medication competency if they are to sign for controlled drugs</p> <p>30 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Wound assessment and wound management plans are in place for 12 wounds reviewed. There were six skin tears and six other wounds including abrasions and ulcers.	Twelve wound charts reviewed. Eight of the 12 did not have documented evidence of review dates.	<p>Ensure that all wound charts have documented evidence of review dates</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

---

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

No data to display
--------------------

End of the report.