# Home of St Barnabas Trust

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Home of St Barnabas Trust

**Premises audited:** Home of St Barnabas

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 15 December 2014 End date: 16 December 2014

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 40

# 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 |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

The Home of St Barnabas is owned and governed by the Anglican Diocese of Dunedin. The home is certified to provide rest home level care for up to 41 residents. On the day of the audit there were 40 residents. The service is managed by an experienced general manager who has been at the service for 18 years (registered nurse). The general manager is supported by deputy manager, a quality coordinator, registered nurses and caregivers. Family and residents interviewed spoke positively overall about the care and support provided.

The service has addressed eight of the ten shortfalls from the previous surveillance audit around collation and analysis of monthly incidents, conducting meetings as per planner, completing education records, maintaining staff records of employment and orientation, aspects of medication management, registered nurses medication competencies, aspects of safe food management and safe food handling training for staff. Further improvements continue to be required around risk assessments and updating care plans when health status changes.

This audit also identified an improvement required around aspects of activity care planning.

## 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 were viewed in reception area of the facility. 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. A complaints register is maintained.

## 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. |

Home of St Barnabas has a current business plan and quality plan to support quality and risk management. Advised that quality information is gathered from internal audits, incidents and accidents, feedback from residents, family and staff. Corrective actions are developed following quality activities to ensure that improvements are followed through. Resident/relative surveys are undertaken annually.

Staff requirements are determined using an organisation service level/skill mix process and documented. The service has a documented training plan. Duty schedules are available for all shifts. Staffing rosters indicate there is suitable staff on duty to care for residents.

## Continuum of service delivery

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

Care plans are developed with the resident by the registered nurses who also have the responsibility for maintaining and reviewing care plans. Residents and family members interviewed state that they are kept involved and informed about the resident's care.

The medication management system includes medication policy and procedures that follows recognised standards. Caregivers and registered nurses responsible for medication administration have current medication competencies completed.

A range of activities are available and residents provide feedback on the programme. St Barnabas Rest Home has food policies/procedures for food services and menu planning appropriate for this type of service. Residents' food preferences are identified and this includes any particular dietary preferences or needs.

## 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. |

The service displays a current building warrant of fitness that expires 3 March 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. The service is restraint free and there are no residents assessed as requiring enablers. There is a restraint register and an enabler’s register.

## 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 service has addressed the previous certification audit finding around updating the infection control policies. The infection control nurse at the Home of St Barnabas completes a monthly infection summary which is discussed at quality and staff meetings. Infection control education is provided. All infections are recorded on the surveillance monitoring summary. The service effectively managed an outbreak of gastroenteritis in September 2014.

## 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)** |
| **Standards** | 0 | 14 | 0 | 1 | 2 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 1 | 2 | 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)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints process and forms for completion are available at the entrance foyer of the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. A review of complaints received since the last surveillance audit in June 2014 was conducted. A complaints register records the details of all complaints (all written), the date of corrective actions taken and is signed off when resolved. Four complaints were from July –October 2014.  Details of the management of all complaints is recorded including letters of follow up, resident, family and staff meetings and response. Complaints are discussed at the three monthly quality meetings.  One complaint from January 2014 to the DHB is now under review process with the health and Disability Commissioner. The service has responded with all required details and is awaiting an outcome.  D13.3h: A complaints procedure is provided to residents within the information pack at entry. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an open disclosure policy in place, information on which is included at the time of admission. The policy states residents or their representative have the right to full and open disclosure. Incident and accident forms are completed by either caregivers or a registered nurse and a copy of any incident relating to individual residents is included in the clinical file. A communication sheet records that families are informed following general practitioner (GP) review, incidents or accidents or if there is a change in resident condition (confirmed by one family member interviewed). Notification of next of kin for the incident reports sampled was confirmed through the clinical files reviewed. The service has introduced a new form which details when family wish to be informed. The service is currently implementing this form for each resident. Details of use of the new forms are documented in staff meetings minutes. There is an interpreter policy in place with information included in the admission booklet.  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 through the admission booklet. The admission booklet is available in large print and can be read to residents if required. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.  D16.1b.ii: Residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.  D16.4b: One family member reported being kept informed when their family member’s health status changes. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Home of St Barnabas rest home is owned by the Anglican Diocese of Dunedin with a trust board providing governance and direction. The facility is managed by an experienced registered nurse who has been in the role for 18 years. The general manager reports monthly to the governing board and chair. Monthly senior management meetings occur with reports tabled relating to activities, kitchen, staffing, occupancy, health and safety, housekeeping. The general manager is supported by the board, a quality coordinator, a kitchen supervisor (deputy manager), registered nurses and care staff. The service has a current business plan which includes a quality and risk management plan for 2014/2015. A quality management system is in place which includes gathering data and information to provide opportunities for quality improvement. The organisation has a philosophy of care which includes the mission statement: “our aim is to promote a friendly, warm, homely environment ensuring individual freedom and security”  ARC, D17.3di: The nurse manager has attended in excess of eight hours of professional development in the past 12 months. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Home of St Barnabas has a current quality and risk management plan for 2014/2015 which includes a quality policy statement, and goals and objectives. Key issues are reported to the monthly senior management meeting. The current objectives include a consumer focus, provision of effective services, certification and contractual requirements, quality and risk management, and continuous improvement.  Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility. The hazard registers are current.  Progress with the quality and risk management plan is monitored through the monthly senior management meetings, three monthly quality meetings and three monthly general staff meetings. Management minutes are maintained (2 December 2014 sighted). Minutes for this meeting include actions to achieve compliance where relevant and are available for staff to read. Staff meetings are held three monthly (19 November 2014 minutes sighted). Internal audits are reported at quality meetings which are held three monthly (minutes sighted for 12 November 2014). This was a previous audit finding that has now been addressed.  Restraint approval meetings are now held three monthly and included as part of the quality meeting. This was a previous audit finding that has now been addressed.  Discussions with the quality coordinator (registered nurse) confirm her involvement in the quality programme by way of policy review and conducting and allocating internal audits. The quality coordinator has been working at least 20 hours weekly to ensure the quality and risk programme is being fully implemented.  Resident meetings take place three monthly with laundry, activities and food/meals as regular agenda items. Minutes sighted for 14 November 2014 and include feedback regarding the resident survey 2014.  The service’s internal audit schedule includes (but not limited to): care planning, resident admissions, code of consumer rights, cleaning, lifting, laundry, medications, and privacy of information, resident hygiene, restraint use, recreation, safety and staff education. The quality programme is reviewed annually – last conducted in December 2013.  The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.  There is an infection control manual, infection control programme (reviewed April 2014) and corresponding policies. There is a restraint use policy and health and safety policies and procedures.  There is an annual staff training programme implemented that is based around policies and procedures. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.  D5.4 The service has policies and procedures to support service delivery. The policies are developed by an external provider with annual review signed off on each policy.  D10.1 Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary certifications and documentation is completed in a timely manner.  The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident reporting policy. Accident/incident forms are commenced by care givers and given to a registered nurse who completes the follow up including resident assessment, treatment and referral if required. Incident forms reviewed evidenced that this is conducted in a timely manner. All incident/accident forms are seen by a registered nurse and/or manager who completes any additional follow up. A registered nurse is allocated the task of collating and analysing data to identify trends. This was a previous audit finding that has now been addressed. Results are discussed with staff through the monthly management meetings, and three monthly staff meetings. Corrective action plans are developed following meetings, audits, and surveys to identify opportunities for improvement. A resident /family survey conducted in July 2014 evidences that residents and families are over all very satisfied with the service.  D19.3: There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. A health and safety officer is appointed.  D19.2g: Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. This has included particular residents identified as high falls-risk and managing this population appropriately. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | 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. There is a discussion of accidents/incidents at the monthly management meetings which incorporates health and safety, at the three monthly quality meetings and three monthly general staff meetings.  There is an open disclosure policy and one family member interviewed stated they are informed of changes in health status and incidents/accidents. A sample of 10 incident reports for November 2014 were reviewed. Reports were completed by a caregiver reporting the incident, with evidence of timely follow up by a registered nurse.  Family are notified appropriately and this is recorded on the incident report and on the family contact sheet. There is documented evidence of clinical follow up by a registered nurse with review of all reports by the manager. Referral to general practitioner, wound specialist and psychiatric services for the elderly has been instigated as require. Monthly accident and incident reviews and summary is compiled by a registered nurse with subsequent analysis and investigations.  D19.3c The service 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 and senior staff confirm an awareness of the requirement to notify relevant authorities in relation to essential notifications.  The service has reported a gastroenteritis outbreak to public health in September 2014 and a resident incident under section 31 in September 2014. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates including the registered nurses, and general practitioners is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files were reviewed (two registered nurses, one diversional therapist and four caregivers). The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Two care givers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Three new staff files reviewed (one diversional therapist and two caregivers) evidence that orientation has been completed. This was a previous audit finding that has now been addressed. Four staff files evidence that appraisals are up to date (three staff have been at the service less than 12 months). This was a previous audit finding that has now been addressed. Employment contracts were evident in six (two are on a collective contract) of seven staff files reviewed (two new staff are reviewing the collective and individual contract). This was a previous audit finding that has now been addressed. Position descriptions are available for staff as evidenced in the human resource manual and in staff files reviewed.  Discussion with the three registered nurses, one general manager, and two care givers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is a completed in-service calendar for year to date for 2014. Records of session content and attendance is available. This was a previous audit finding that has now been addressed. The annual training programme exceeds eight hours annually. Care givers have completed either the national certificate in care of the elderly or are working towards completion. The manager and registered nurses attend external training including conferences, seminars and sessions provided by the local DHB. The facility manager attends a two monthly provider meeting with the DHB which includes education and training related to managing the facility. Education is conducted as face to face sessions, self-directed learning or attendance at external providers. The service has recently implemented an on-line training programme that is readily available for all staff and is part of the education planning for 2015.  Education provided since the last audit in June 2014 includes but not limited to: elder abuse, communication, open disclosure, aging process, diabetes, chemical safety , documentation , fire training and fire drill six monthly (15 August 2014). |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staff manual includes a staff rationale and skill mix policy. Sufficient staff are rostered on to manage the care requirements of the rest home residents. A minimum of two staff are rostered on at any one time with the registered nurses providing on-call after hours and weekends. The roster includes the general manager who works 40 hours per week. There are four registered nurses who each work part time to cover Monday to Saturday with two RN’s on duty during two days of the week. There is a staff member with a current first aid certificate and current medication competency on every shift. The service also employs cleaning staff, cooks and kitchen hands and a maintenance person. The diversional therapist recently appointed is employed to work ten am – five pm to cover activity later in the afternoon (previously the DT finished at 3pm). Interviews with three registered nurses, two caregivers, five residents and one family member identify that staffing is adequate to meet the needs of residents. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are medication management policies and procedures in place. The service uses four weekly blister dose medication packs for all residents. Ten of ten medication charts have photo identifications and allergies documented.  There is a signed agreement with the supplying pharmacy. The three registered nurses advised that the blister packs are checked and reconciled against medication charts upon arrival to the facility by two registered nurses and signed off when this check has been completed.  There are two medication trolleys at the service. Both medication trolleys are locked and kept in the nurse’s station/treatment room. All trolleys are locked when not in use. One caregiver was observed safely administering medications - checking the medication chart, the medico pack and then observing the resident taking the medication and completing documentation.  Staff sign for the administration of medications on medication sheets held with the medicines. A list of specimen signatures and competencies is kept in the front of each (two) medication folders. The medication fridge temperatures are monitored daily.  Registered nurses and caregivers administer medications. Eight caregivers that administer medications have annual competencies completed. There are four registered nurses that have competencies completed. This was a previous audit finding that has now been addressed.  Unused medications and expired medications are returned to pharmacy. Medication charts for 10 residents were reviewed.  D16.5.e.i.2; All ten medication charts show evidence that the GP had reviewed the medications three monthly. Medication profiles are legible, up to date and signed and dated by the GP. Long term medications have been signed and dated by the GP when discontinued. This was a previous audit finding that has now been addressed.  Eye drops sighted had evidence of a recorded date on opening. The service records all medication errors as incidents/accidents and these are followed up on a monthly basis. Where appropriate, corrective action is discussed at the staff meetings and registered nurse meetings.  The service has a policy and procedure on residents who wish to self-medicate that requires three monthly assessments by GP of the resident's on-going ability to safely self-medicate and a resident competency review form. There is currently one resident self-medicating at St Barnabas Rest Home and competency has been completed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | St Barnabas Rest Home has a food service that is managed by an experienced cook (deputy manager). All meals for St Barnabas Rest Home residents are prepared and cooked on site. The main cook has been in the role for 30 years and is supported by three other cooks. There are also four tea cooks and six kitchen hands. All cooks have completed food safety and all caregivers have completed food handling since the last audit. This was a previous audit finding that has now been addressed.  The four weekly menus is designed by the organisation's dietician with input from the cooks. The food service is notified of dietary requirements via a dietary requirements form which is completed by the registered nurse and sent through to the kitchen. It includes likes and dislikes, modified diets and preferences. Residents diet profiles are kept in a folder in the kitchen and likes and dislikes are on the kitchen whiteboard which can only be seen by kitchen staff. The cook confirmed that food supplements, milk shakes and extra puddings are prepared for residents that have weight loss. Home - made baking is available for morning and afternoon tea. The service provides special equipment e.g. utensils, lip plates and sipper cups as required.  Meals are served directly to the residents from the bane marie which is taken into the dining room. Meals taken to residents rooms are served directly from the bane marie and covered in foil and taken immediately to the resident. Breakfast is prepared in a smaller servery and delivered to resident’s rooms.  There is evidence of documented recordings of hot food temperature recordings. This was a previous audit finding that has now been addressed. Fridge and freezer temperatures are monitored daily in the main kitchen and temperature monitoring of the fridge in the breakfast servery. This was a previous audit finding that has now been addressed. Food stored in the fridges and freezer is covered and labelled.  A registered dietician is available to conduct nutritional assessments on all residents and develops nutritional plans for residents with identified weight issues if required. Information is documented in the long term care plan if there is an identified nutritional issue.  Resident weights are monitored three monthly or more frequently if required.  Residents and relatives interviewed were complimentary of the food service. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | The previous audit identified that risk assessments were not completed for residents with on-going pain. A review of five resident files for this audit indicates that completion and review of risk assessments including continence, nutrition, falls and activity has not been addressed. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Five resident files were reviewed. All five identified that an initial nursing assessment and care plan was completed within 24 hours and all five files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the registered nurses and amended when current health changes with exceptions (# link 1.3.8.2). Five of five care plans evidenced evaluations completed at least six monthly. There is no evidence that one resident has an activity assessment completed (# link 1.3.4.2) or care plan completed (# link 1.3.7.1). The care being provided is consistent with the needs of residents for all five files sampled. Good care is evidenced by discussions with residents, families, caregivers, and registered nurses. A review of short term care plans (# link 1.3.8.2), long term care plans, evaluations and progress notes demonstrate integration. There is evidence of at least three monthly medical reviews.  The staff educator is responsible for the education programme and ensures staff have the opportunity to receive updated information and follow best practice guidelines. Residents' care plans are completed by the registered nurses. Care delivery is recorded by caregivers on each shift and evaluated by registered nurses in the progress notes when there are any changes but at least weekly. When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit or a specialist referral. The two caregivers and three registered nurses interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, wheelchairs, sit on weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. Five residents interviewed and one family member interviewed were complimentary of care received at the facility.  D18.3 and 4: Dressing supplies are available. Wound assessment and wound management plans are in place for three residents with wounds. There are no pressure areas.  The registered nurses interviewed described the referral process and related form for referral to a wound specialist or continence nurse. 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.  Continence management and wound management in-service have been provided.  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 is maintained. |
| Standard 1.3.7: Planned Activities  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. | PA Low | There is one experienced diversional therapist (DT) that has been employed at the service since November 2014. The previous activities coordinator resigned from her position in August 2014 and there has been another staff member fulfilling the role. The new DT has previously worked for many years in the aged care sector and has been a qualified DT since 2012. The new DT is employed to provide more activity hours than previously. The hours are now ten am- five pm allowing for activities later in the afternoon. There is one volunteer and friends of St Barnabas (10) that help out as required including reading the newspaper on Saturdays and running a singing group. There is a two weekly plan of activities, based on assessed needs and wishes of the residents, posted on the hallway notice board and written daily on a white board in the lounges. The DT discusses the programme at the management meeting. Resident meetings occur three –four monthly with activities as an agenda item. There is visiting and sharing of activities with other facilities in the area. Residents are encouraged to participate in activities but remains voluntary.  There is a wide range of activities offered, that reflects the resident needs including but not limited to: newspaper reading, communion, church services, and exercises, visiting entertainment weekly, seasonal celebrations, music, quizzes, baking, craft, games, happy hour, van outings, shopping, movies, housie and crosswords. There is also attendance at the South Dunedin community centre, visits to the Mosgiel RSA and visits from the SPCA dog squad every two weeks.  Five resident files reviewed showed that improvements are required in activity assessment (# link 1.3.4.2), activity care plan reviews and activity progress notes.  The DT has a current first aid certificate. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | The long term care plan is developed within three weeks of admission in all five files reviewed.  D16.4a: All five resident files evidence that care plans are evaluated at least six monthly by the registered nurse. Four of five files evidence the care plans are reviewed when there is a change in the resident’s condition. This was a previous audit finding that still requires improvement.  There are short term care plans to focus on acute and short-term issues. STCPs reviewed evidenced evaluation and are signed off by the registered nurse. Short term care issues were evidenced for blood sugar monitoring, nutrition needs, post cerebral vascular accident, and challenging behaviour. There was no evidence of short term care plans or updated to the long term care plan for three residents. This was a previous audit finding that still requires improvement.  Caregivers interviewed confirmed that they are updated as to/or any changes to resident need at handover between shifts.  General practitioners conduct medication and clinical reviews for residents either three monthly (residents recorded as stable and can be seen three monthly) or when requested. All five resident files reviewed identified that the GP had seen the resident within two working days. It was noted in all five resident files reviewed, that the GP has assessed the resident as stable and is to be seen three monthly. Documentation of GP visits were evident that reviews were occurring in the timeframes documented in all 10 resident medication and medical notes reviewed. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service displays a current building warrant of fitness which expires 3 March 2015. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection control policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the senior management meetings, quality meetings and three monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. The infection control programme was reviewed in April 2014. A registered nurse is the designated infection control nurse. The service effectively managed a gastroenteritis outbreak involving 10 residents and four staff in September 2014. Public health was promptly notified. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraint, enablers and the management of challenging behaviours. The service is restraint free. There are no residents using enablers. Policy dictates that enablers should be voluntary and the least restrictive option possible. A registered nurse (restraint coordinator), two registered nurses, and two caregivers are familiar with this. Restraint/enabler use is discussed at management meetings, at staff meetings and at the three monthly quality meeting where restraint approval is discussed.  Staff received training around restraint minimisation and safe practice in March 2014. Management of challenging behaviours education was provided in May 2014. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers should this be required. |

# 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)** |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | Assessments are conducted in an appropriate and private manner. Assessments and care plans are detailed and include input from a general practitioner, support services and medical specialists as appropriate. Assessment tools such as pain, pressure area risk, falls risk, continence and nutritional assessments are completed on admission and reviewed six monthly. Pain assessments were evident and this is an improvement on previous audit. | One resident with continence issues does not evidence assessment reviewed six monthly, two residents do not show evidence that nutritional assessments have been reviewed six monthly, one resident with falls does not show evidence of falls assessments completed six monthly, and one resident does not have an activity assessment completed. | Ensure that all resident risk assessments are reviewed six monthly or earlier to support any change in resident identified needs.  60 days |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Criterion 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. | PA Low | There is one experienced diversional therapist (DT) that has been employed at the service since November 2014. Five resident files reviewed showed that improvements are required in activity assessment, activity care plan reviews and activity progress notes. | (i) There is one resident with no evidence of an activity care plan. (ii) Four files reviewed do not show evidence of six monthly care plan review. (iii) Activity progress notes have not been completed since May 2014. | (i) & (ii) Ensure that all residents have activity plans completed and that these are reviewed six monthly. (iii) Ensure that the DT completes activity progress notes.  60 days |
| Criterion 1.3.8.3  Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | There are short term care plans (SCTP’s) to focus on acute and short-term issues. STCPs reviewed evidenced evaluation and are signed off by the registered nurse. Short term care issues were evidenced for blood sugar monitoring, nutrition needs, post cerebral vascular accident, and challenging behaviour. | (i) There was no short term care plan for one resident with a urinary tract infection and two residents with a chest infection (GP had prescribed antibiotics). (ii) Changes to the long term care plan have not been made for one resident with identified challenging behaviour. (iii) There was no evidence of neurological observations completed for a resident with a documented head injury. | i) Ensure that short term care plans are developed for all residents with infections. (ii) Ensure that changes are made to the long term care plan where required. (iii) Ensure that all residents with head injury have neurological observations completed.  60 days |

# 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, these 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.