

# Sisters of St Joseph of the Sacred Heart (NZ) Trust Board

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## 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>	Sisters of St Joseph of the Sacred Heart (NZ) Trust	
<b>Premises audited:</b>	Mary MacKillop Care	
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 1 December 2015	End date: 2 December 2015
<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

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## 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
	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

Mary MacKillop Care is owned and operated by the Sisters of St Joseph. The service is certified to provide rest home and hospital level care for up to 31 residents. On the day of the audit, there were 30 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents and staff files, observations and interviews with residents, relatives, staff and management.

The nurse manager is appropriately qualified and experienced. Feedback from residents and relatives is positive.

One of two shortfalls from the previous certification audit has been addressed. This was around reporting of incidents. Improvement continues to be required around the storage of dry foods.

This audit has identified areas requiring improvement around wound documentation and care plans.

## 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.
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Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family are well informed including of changes in residents' health. The nurse manager and clinical/quality coordinator have an open door policy.

## 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.
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Mary MacKillop Care has an established quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to facility meetings. An annual resident/relative satisfaction survey is completed and there are regular resident meetings. Incidents are documented and there is immediate follow up from a registered nurse. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely.

## 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>
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Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the residents' assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The building holds a current warrant of fitness.

## 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.
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A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers aligns with the definition in the standards. There are no restraints or enablers being used. Staff are trained in restraint minimisation and challenging behaviour management.

## 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.
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Appropriate infection control practices were observed during the audit. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

## 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	13	0	1	2	0	0
<b>Criteria</b>	0	36	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)
<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>	FA	<p>The complaints policy and procedures has been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. Two complaints were received in 2014 and one in 2015 to date and review of these shows appropriate processes have been followed within the expected timeframes. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Six residents (three from the hospital and three from the rest home) and four family members interviewed (from hospital residents), stated they are informed of changes in health status and incidents/accidents. This was confirmed on 13 incident forms sighted. Residents and family members also stated they were welcomed on entry and given time and explanation about services and procedures. Resident meetings occur two monthly and the managers have an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau has difficulty</p>

		with written or spoken English, interpreter services are made available.
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Mary MacKillop Care provides care for up to 31 residents at rest home and hospital level care. On the day of the audit, there were 16 rest home level residents and 14 hospital residents. All rooms can be dual purpose and the service can cater for up to a maximum of 19 hospital level residents. All current residents are under the aged related residential care contract.</p> <p>An experienced nurse manager, who has been in the role since 2004, manages the service. A clinical/quality coordinator (registered nurse) who has been in the role since September 2015 supports her. The current business plan and quality and risk management plans have been implemented. The nurse manager has completed in excess of eight hours of training relating to the management of a rest home in 2015.</p> <p>The 2015 – 2016 business plan documents the mission and philosophy of the organisation. It includes a review of the previous goals.</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>	FA	<p>Progress with the quality and risk management programme has been monitored through monthly-incorporated (quality/registered staff) and staff meetings. A comprehensive monthly quality report is completed and provided to staff with meeting minutes. Meeting minutes have been maintained and staff were expected to read the minutes and sign off when read. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with staff (including five caregivers, one registered nurse, the clinical/quality coordinator and the cook) confirmed their involvement in the quality programme. Resident meetings have been held two monthly. Data is collected on complaints, accidents, incidents, infection control and restraint use (of which there is none). The internal audit schedule for 2015 has been implemented. Areas of non-compliance identified at audits have been actioned for improvement. The service has implemented a health and safety management system and recently retained tertiary accreditation in a workplace safety audit. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. The death/Tangihanga policy and procedure outlines immediate action to be taken upon a resident's death. Policy has been amended to meet InterRAI requirements. Falls prevention strategies are implemented for individual residents.</p>

		Residents' and relatives are surveyed to gather feedback on the service provided (with positive results) and the outcomes are communicated to residents, staff and families.
<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>	FA	Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for November 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident and all have been signed off. This is an improvement since the previous audit. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Monthly and annual review of incidents is completed.
<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>	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 is kept. Five staff files were reviewed (the clinical/quality coordinator, the activities coordinator, the chef, one registered nurse and one caregiver) and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 10 years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff. A two yearly rotating in-service education calendar was implemented and exceeds eight hours annually and has covered appropriate topics. The registered nurses attend external training including seminars and education sessions with the local DHB and the hospice.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	Mary MacKillop Care has a weekly roster in place, which provides sufficient staffing cover for the provision of care and service to residents. There is a registered nurse on duty at all times, in addition to the manager who works 40 hours per week, and the clinical/quality coordinator who works 32 hours per week. Caregivers, residents and family interviewed advised that sufficient staff are rostered on for each shift.
Standard 1.3.12: Medicine Management	FA	The service uses individualised medication blister packs, checked-in on delivery

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>by a registered nurse. A registered nurse was observed administering medications correctly. Medications and associated documentation were stored safely and securely. All medication checks were completed and they met requirements. Resident photos and documented allergies or nil known were on all 10 medication charts reviewed. An annual medication administration competency is completed for all staff administering medications and medication training had been conducted.</p> <p>There is a self-medicating resident's policy and procedures in place. There were currently three residents who self-administered medications and all have a current competency assessment. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. All 10 medication charts reviewed, recorded indication for use of 'as required' medication by the GP. Medication charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart signed.</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>PA Low</p>	<p>All meals at the service are prepared and cooked on site. A dietitian has reviewed the six weekly winter and summer menu. Meals are prepared in a well-appointed kitchen and bain-maries are used to transport food to the dining rooms. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. The service records all fridge and freezer temperatures. Not all dry food decanted from the original container had the best before/use by date recorded. This shortfall identified in the previous audit continues to require improvement. Staff were observed serving and assisting residents with their lunchtime meals and drinks. Diets are modified as required. Food services staff know resident dietary profiles and likes and dislikes and any changes are communicated to the kitchen via the clinical manager. Six monthly nutritional assessments are completed for all residents and more frequently if required. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Resident meetings and surveys allow the opportunity for resident feedback on meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service.</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</p>	<p>PA Moderate</p>	<p>Care plan interventions reflect the assessments conducted, with one exception where these have not been updated as needs changed (link 1.3.8.3). Interviews with staff, residents and relatives confirmed involvement of families in the care</p>

desired outcomes.		planning process. Dressing supplies are available and a treatment room stocked for use. Continence products are available and resident files included 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. Wound assessment and wound management plans were in place for six residents (including three pressure areas) with links documented between short-term care wound management and long-term care plans. Not all wound assessments were completed comprehensively for two pressure areas. One resident requiring two hourly turns does not have these fully documented.
<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>	FA	The activities coordinator works two days per week and coordinates a six days per week programme run by external contractors (such as a tai chi teacher) and the pastoral care team. The programme is planned monthly and residents receive a copy of planned weekly activities. Activities planned for the day are displayed on notice boards around the facility. An activity plan is developed for each individual resident, based on assessed needs. Monthly progress notes are recorded. The activity plan is reviewed six monthly along with the residents nursing care plan. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. The service hires a van that is used for resident outings. Residents were observed participating in activities on the day of audit. Resident meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Moderate	Four of five care plans reviewed were not updated as changes were noted in care requirements. Care plan evaluations are comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Changes were documented in the evaluations. Short-term care plans are utilised for residents and any changes to the long-term care plan were dated and signed. Short-term care plans were in use. Care plans are evaluated within the required timeframes.
<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>	FA	The building holds a current warrant of fitness.

<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 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. Monthly registers of types of infection are developed and analysed with results provided to staff at the monthly integrated and staff meetings. No outbreaks have been reported.</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>The service is committed to restraint minimisation and safe practice, as evidenced in the restraint policy and interviews with staff. There are no residents requiring restraint or enablers.</p> <p>There is a documented definition of restraint and enablers in the policies, which is congruent with the definition in NZS 8134.0.</p> <p>Staff have had training around restraint minimisation and the management of challenging behaviours.</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 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	<p>There is a chiller, a milk fridge and two freezers. All food in these was appropriately stored, including covering and dated. Dry foods are stored in bins in the kitchen for bulk items and in containers in the pantry for items with lesser quantities. Since the previous audit, the chef has begun recording the dates that bulk items such as flour and sugar, are decanted and some smaller containers had the packet containing the best before date in the container. However not all decanted foods had the best before date recorded.</p>	<p>Dry foods decanted into containers in the pantry do not always have the best before/use by date recorded.</p>	<p>Ensure that the best before/use by date is available for all decanted foods.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are</p>	PA Moderate	<p>The service has a recently implemented ‘simple wound’ assessment and plan, which includes a basic assessment and plan. This is intended to be used for</p>	<p>Two of three pressure injuries (one grade-one and one grade-two) did not have a comprehensive wound</p>	<p>Ensure all pressure injuries have a comprehensive wound assessment</p>

<p>consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>simple skin tears or similar as reported by the clinical/quality manager and the registered nurse interviewed. This form had been used for two pressure injuries. The third pressure injury had an appropriate assessment. A two hourly turning form is available but had not been utilised for the one resident requiring two hourly turns. Progress notes frequently document 'turned regularly' but progress notes are not written every shift.</p>	<p>assessment completed. Two hourly turns were not documented as occurring, for the one resident requiring this.</p>	<p>completed. Ensure that appropriate interventions to manage pressure injury risk, are provided and documented.  60 days</p>
<p>Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Moderate</p>	<p>In care plans sampled, each area of the care plan had a comprehensive documented evaluation. In one of the five care plans sampled, the evaluations contained the required changes to care and the care plan had been updated to reflect these. Two of five residents had experienced significant recent changes in needs, and care plans had not been updated to reflect these. There were changes to care plans for some historical changes in need (in four care plans sampled).</p>	<p>Four of five care plans sampled (two rest home and two hospital residents) had changes to care requirements documented in the evaluations, but these were not reflected in the care plan. Additionally two of these files (one rest home and one hospital) had not had the care plan updated following a significant decline in health status.</p>	<p>Ensure care plans are updated as needs change.  60 days</p>

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

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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
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End of the report.