

St Josephs Home of Compassion Heretaunga Limited - St Josephs Home of Compassion

Introduction

This report records the results of a Certification 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:

Legal entity:	St Josephs Home of Compassion Heretaunga Limited
Premises audited:	St Josephs Home of Compassion
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 15 August 2016 End date: 16 August 2016
Proposed changes to current services (if any):	Add medical level care to their current hospital certification
Total beds occupied across all premises included in the audit on the first day of the audit:	86



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
	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

St Joseph's Home of Compassion is owned and operated by The Sisters of Compassion and overseen by a board of directors. The facility is certified to provide rest home, hospital level (geriatric) and dementia level care for up to 88 residents. This audit also included verifying the service as suitable to provide medical level care under their current hospital certification.

The manager is a registered nurse both management and aged care experience. She is supported by an assistant manager/clinical manager who is a senior registered nurse. Residents, relatives and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against the relevant 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 service is commended for achieving continued improvement ratings around pastoral care, good practice, quality programme, restraint minimisation and infection surveillance.

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.

All standards applicable to this service fully attained with some standards exceeded.

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided.

There is an established system for the management of complaints, which meets guidelines required by the Health and Disability Commissioner.

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.

Services are planned, coordinated, and are appropriate to the needs of the residents. A clinical manager and senior registered nurse are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A

quality and risk management programme is embedded. Data is collected, analysed and discussed and changes made as a result of trend analysis. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

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.		Standards applicable to this service fully attained.
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There is a comprehensive admission package on all services and levels of care provided at St Joseph's Home of Compassion. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and develops the care plan with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were reviewed at least six monthly. Resident files included the general practitioner, specialist and allied health notes.

Medication policies reflect legislative requirements and guidelines. Registered nurses are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts reviewed meet prescribing requirements and were reviewed at least three monthly.

A diversional therapist oversees the activity team and coordinates the activity programme for the rest home, hospital and dementia level of care residents. The programme includes community visitors and outings, entertainment and activities that meet the

individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Residents and families report satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There are nutritious snacks available 24 hours.

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.
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There are documented processes for the management of waste and hazardous substances in place. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised with ensuites or access to communal facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Systems and supplies are in place for essential, emergency and security services. All registered nurses hold a current first aid certificate.

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.

All standards applicable to this service fully attained with some standards exceeded.

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. A register is maintained by the restraint coordinator. On the days of audit, five residents were using restraints and one resident was using enablers. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

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.

All standards applicable to this service fully attained with some standards exceeded.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification

and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

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	4	46	0	0	0	0	0
Criteria	5	96	0	0	0	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](#).

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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>St Joseph's Home of Compassion (St Josephs) policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with care staff (four caregivers, two registered nurses (RNs) and two activities staff) confirmed their understanding of the Code. Seven residents (four rest home level and three hospital level) and seven relatives (two dementia, two rest home and three hospital level) interviewed, confirmed that staff respect privacy, and support residents in making choices.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consents including photographs were obtained on admission and sighted in nine of nine resident files reviewed (four hospital including one younger person, three rest home residents including one respite care resident and two dementia level of care residents). Advance directives for continuing care (where appropriate) were completed and on the resident files. Resuscitation plans were sighted in all files and were signed appropriately. Copies of EPOA were present in resident files. The EPOA of two dementia care residents had been activated.</p>

		<p>An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers and registered nurses interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p> <p>All resident's files sampled had signed admission agreements on file.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. Staff and residents identify the chaplain and pastoral care coordinator as an advocate. The resident files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care.</p>
<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 service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaints register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in management and staff meetings. All complaints received have been documented as resolved with appropriate corrective actions implemented.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. The information pack for the dementia unit includes dementia specific information. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	CI	<p>A tour of the service confirmed they support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>The service has a philosophy that includes its Christian ethos, promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with caregivers described how choice is incorporated into resident cares.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The Māori health plan policy for the organisation references local Māori healthcare providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning, and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. At the time of audit, there was one resident who identified as Māori. This was reflected in the care plan as well as the resident not wishing any special cultural care.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic,</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their</p>

cultural, spiritual values, and beliefs.		values and beliefs.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities. The two monthly staff meetings and monthly clinical based meetings include discussions around professional boundaries and concerns as they arise. Management provides guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>Policies and procedures are aligned with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff.</p> <p>An annual in-service training programme is implemented as per the training plan with training for registered nurses from the DHB. The service benchmarks with other services and analyses data to identify opportunities to improve resident outcomes. Feedback is provided to staff via the staff/quality meetings.</p> <p>There is a minimum of two registered nurses on each shift and caregivers are described by residents and family as being caring and competent.</p> <p>Good practice initiatives since the previous audit have included:</p> <p>1) The development of resident information pamphlet around pain management. Families and the residents have indicated that they now have a clearer idea of medication and treatment. They understand why a particular medication may be used and the likely changes that could occur in the future. This allows them to make a more informed decision on use of these medications.</p> <p>2) The development of a leadership programme for registered nurses. This in-depth programme has been attended by all the registered nurses. It was developed by the organisation following a review of adverse events and analysis of causes. The service reports that the registered nurses are using the skills they had learnt and were more confident in their dealings with the caregivers and with managing their roles. Link to falls reduction and pressure injury reduction – (1.2.3.6) and reduction in infections (3.5.7).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	FA	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>system. All 13 adverse events reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available. The service has set up Wi-Fi in a small lounge for residents and families to use. Families interviewed were very positive regarding this initiative.</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>St Joseph's Home of Compassion is owned and operated by The Sisters of Compassion and overseen by a board of directors. The facility is certified to provide rest home, hospital level (geriatric) and dementia care for up to 88 residents. This audit also included verifying the service as suitable to provide 'medical' level care under their current hospital certification. The service has links to allied health including physiotherapist. There is sufficient space in resident rooms, appropriate equipment is available and staff are trained around current medical conditions.</p> <p>There were 86 residents during this audit, including one on a younger person with disability (YPD) contract and two respite residents. All other residents were on the Aged Related Care contract. The service has 72 dual-purpose beds in the rest home/hospital wing. There were 44 residents at hospital level (including the YPD resident) 26 residents' at rest home level (including two respite residents and 16 residents at dementia level).</p> <p>The strategic plan 2016 to 2020 and the 2016 quality plan document organisational goals and describes the vision, values and objectives of the service. Annual goals are linked to the business plan and reflect regular reviews.</p> <p>The manager oversees the service; she has managed the service for 15 years. The manager is supported by the assistant manager /clinical manager and two clinical lead registered nurses.</p> <p>The manager and assistant manager have maintained at least eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to</p>	<p>FA</p>	<p>The assistant manager and senior registered nurse covers during the temporary absence of the manager.</p>

consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The service continues to implement a comprehensive quality and risk management system that is well embedded into practice. Quality and risk performance is reported across facility meetings. Discussions with the staff (the manager, assistant manager, care leads and registered nurse) reflected staff involvement in quality and risk management processes. Review of meeting minutes/quality initiatives and analysis, demonstrates a culture of quality improvements.</p> <p>Annual resident and relative surveys are completed with results communicated to residents and staff. Survey results reflect very high levels of satisfaction.</p> <p>There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff.</p> <p>The quality-monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements. Key performance areas are benchmarked against other services. Quality improvement plans are developed when service shortfalls are identified.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.</p> <p>Falls prevention strategies are in place including (but not limited to) sensor mats, increased monitoring, identification and meeting of individual needs and mattress perimeter guards.</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</p>	FA	<p>There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of 13 incident/accident forms identified that forms are fully completed and include</p>

<p>family/whānau of choice in an open manner.</p>		<p>follow-up by a registered nurse. Neurological observations are completed for any suspected injury to the head. The registered nurses are involved in the adverse event process. There is a debriefing process for all critical incidents that includes a staff debrief and a review of the incident.</p> <p>The manager was able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death.</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>Human resources policies are in place to support recruitment, orientation and staff management. Nine staff files reviewed (two registered nurse team leaders, two registered nurses, the activities coordinator and four caregivers), all included a comprehensive recruitment process which included reference checking, signed employment contracts and job descriptions; completed orientation programmes and annual performance appraisals.</p> <p>A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. Most training is provided during full day training sessions with additional training provided as needed and incidental training is provided according to identified need and at staff request. There is an attendance register for each training session and an individual staff member record of training. All caregivers who work in the dementia unit have completed the required dementia standards.</p> <p>Registered nurses are supported to maintain their professional competency. There are implemented competencies for registered nurses including (but not limited to) medication competencies, restraint competencies, controlled drug competencies and insulin competencies.</p> <p>The home provides palliative care services and works closely with Te Omanga Hospice. Palliative care training is provided to staff.</p> <p>A planned leadership programme has been run for the registered nurses and the benefits of this are shown in improved outcomes for residents.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale.</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>Staff working on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed report there are sufficient staff numbers.</p> <p>The management team at St Josephs have ensured a high level of clinical supervision across all areas. The assistant manager works Monday to Friday plus on call and the RN manager is also available as needed. The roster allows for an additional clinical lead RN during the AM shift Monday to Sunday. There is also a RN 'float' nurse Monday to Friday. The service employs an RN nurse educator 16 hours a week.</p> <p>The roster has two RNs for the AM shift and two for the PM shift who each take responsibility for the rest home and dementia units (as well as the hospital residents). One RN is on night shift.</p> <p>Caregivers are rostered to each of the hospital, dementia and rest home units.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Families and prospective residents are invited to visit the complex, even before confirming admission. Pre-admission information packs including information on the dementia care service is provided for families and residents prior to or on admission. Nine admission agreements for residents were signed and align with all contractual requirements. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or</p>	<p>FA</p>	<p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.</p>

transfer from services.		
<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>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses who administer medications have been assessed for competency on an annual basis. Registered nurses complete syringe driver training. Education around safe medication administration has been provided. Caregivers on nightshift have completed medication competency to check medications. Standing orders were current and used for hospital level residents. There were no residents self-medicating on the day of audit. All medications are stored safely. All eye drops are dated on opening. The medication fridge is monitored daily.</p> <p>All 18 medication charts reviewed (eight hospital, six rest home and four dementia care) met legislative prescribing requirements. The GP has reviewed the medication charts three monthly.</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>	FA	<p>All meals at St Joseph's Home of Compassion are prepared and cooked on site by qualified cooks. The cooks are supported by morning and afternoon kitchenhands. All staff have attended food safety and hygiene training. There is a six weekly seasonal menu, which had been reviewed by a dietitian. Meals are transported in bain-maries and served from the kitchenette in rest home, hospital and dementia care kitchenettes. Dietary needs are known with individual likes and dislikes accommodated. Dietary requirements, cultural and religious food preferences are met. Additional or modified foods are also provided by the service. Special diets include gluten free, vegetarian and low fat/low salt. Dislikes are accommodated.</p> <p>Staff were observed assisting residents with their meals and drinks in the hospital and rest home dining room. Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. There are nutritious snacks available in the dementia unit 24 hours.</p> <p>Fridge, freezer and end-cooked temperatures are monitored daily. A kitchen cleaning schedule is in place and implemented.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is</p>	FA	<p>There is an admission information policy. The reasons for declining entry would be if the service were unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was</p>

declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The RN completes an initial assessment on admission including risk assessment tools. An InterRAI assessment is undertaken within 21 days of admission and six monthly, or earlier due to health changes. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others. InterRAI assessments, assessment notes and summary were in place for all resident files sampled. The long-term care plans in place reflected the outcome of the assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident lifestyle plans reviewed were resident-focused and individualised. Overall, identified support needs were included in the care plans for all resident's files reviewed. A short-term care plan was in place for the respite care resident. The two files of residents in the dementia care unit contained a 24-hour behaviour management plan. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrate service integration and evidence of allied health care professionals involved in the care of the resident such as the physiotherapist, hospice service, pain management team and mental health services. Short-term care plans were in place for short-term needs.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the resident file. Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds and skin tears. There was one pressure injury on the day of audit. There is a range of equipment readily available to minimise pressure injuries. Chronic wounds have been linked to the long-term lifestyle plans. There was evidence of wound nurse specialist involvement in the management of the pressure injury.

		<p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences.</p> <p>Monitoring occurs for weight, vital signs, blood glucose, and pain, challenging behaviour, wounds restraint, continence and two hourly positioning. Registered nurses review the monitoring charts and report identified concerns to the GP, nurse practitioner or nurse specialist.</p> <p>Short-term care plans document appropriate interventions to manage short-term changes in health.</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 service has a qualified diversional therapist (DT) who oversees two recreation officers (both are currently completing the DT qualification). The activity team provide an integrated rest home and hospital activity plan Monday to Friday. There is a separate activity programme for residents in the dementia care unit. There are organized activities and other activities initiated by the caregivers in the weekends. Activities are held in several locations within the facility including the activity room. A variety of activities meets the abilities of all residents. A massage therapist is employed eight hours a week and spends one-on-one time with residents who choose not to join in group activity or are unable to participate in activities.</p> <p>Volunteers involved in the activity programme include retired Priests and Sisters, secondary school students, kindergarten children, pet therapy owners and community speakers. Entertainers attend the home regularly and there are regular outings and drives for all residents. Residents are supported to attend religious services including daily mass in the on-site chapel. Residents are encouraged to maintain links with the community and include, card groups, Cossie club, Catholic Women's League, Tai Chi and mobile library service. Special events and festivities are celebrated and families invited to attend.</p> <p>An activity team member provides an afternoon programme from 1 - 4pm in the dementia care unit (observed on the day of audit). Caregivers in the dementia unit facilitate small group or individual activities at other times. There are adequate resources available.</p> <p>An activity assessment and plan is completed on admission in consultation with the resident/family (as appropriate) and reviewed six monthly.</p> <p>Residents and families have the opportunity to feedback on the activity programme through</p>

		meetings and surveys.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans reviewed were evaluated by the RN within three weeks of admission. Long-term lifestyle plans have been reviewed at least six monthly or earlier for any health changes. The written evaluation documents the resident's progress against identified goals. The GP reviews the residents at least three monthly or earlier if required. The multidisciplinary team includes the clinical leader, DT, physiotherapist, pastoral carer, resident/relative and any other allied health professional involved in the care of the resident. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. Changes are made to care plans.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place. Safety data sheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored in locked areas throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit.</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>	FA	<p>The building has a current building warrant of fitness that expires 19 February 2017.</p> <p>The full-time maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. Monthly inspections include call bell testing and hot water temperature monitoring. Temperature recordings reviewed were between 43-45 degrees Celsius. Essential contractors are available 24 hours. Electrical testing is completed annually. An external contractor completes annual calibration and functional checks of medical</p>

		<p>equipment.</p> <p>The facility has wide corridors with handrails and sufficient space for residents to safely mobilise using mobility aids. There is to safe access the outdoor areas. Seating and shade is provided.</p> <p>The dementia care unit has exit and entry points to the safe outdoor courtyards, which provide seating and shade.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Toilet and shower facilities are of an appropriate design to meet the needs of the residents. The resident rooms in the newer rest home wing and dementia unit have ensuites. In the hospital wing, there is a mix of resident rooms with and without ensuites. There are adequate numbers of communal toilets and shower rooms. Communal toilet facilities have a system that indicates if it is engaged or vacant. There is a large bathroom with a bath.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All resident rooms are single. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas within the facility include separate rest home and hospital dining rooms, main lounge and smaller lounges and conservatories. There are seating alcoves throughout the facility. Seating and space is arranged to allow both individual and group activities to occur. The service developed a smaller lounge into a quieter lounge with skype and email availability.</p> <p>There is a separate dining room and two lounge areas in the dementia unit. The outlook from the dementia unit provides an open view over sport grounds.</p>
<p>Standard 1.4.6: Cleaning And Laundry</p>	FA	<p>There are adequate policies and procedures to provide guidelines regarding the safe and</p>

<p>Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>efficient use of laundry services. There are dedicated laundry and cleaning staff seven days a week. All linen and personal clothing is laundered on-site. Residents and family interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes. The cleaner's trolleys are kept in designated locked areas when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available including tank water situated outside of the kitchen with tap access within the kitchen area. This provides for a further 50,000 litres of water. There is a civil defence food storage cupboard with at least three days in the event of an emergency. There is a generator for backup power that maintains full running of all services including laundry, call bells and lighting throughout the facility during power failures.</p> <p>The fire evacuation scheme was approved by the fire service 25 February 2015 following the opening of the new wing. Six monthly fire drills have occurred. Fire safety is completed with new staff as part of the health and safety induction and is ongoing as part of the education plan. There is a first aider on duty at all times.</p> <p>Resident's rooms, communal bathrooms and living areas all have call bells. Security policies and procedures are documented and implemented by staff. The buildings are secure at night after hours with doorbell access. All external doors are alarmed to the call bell system, which is linked to staff pagers.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There are sufficient doors and opening windows for ventilation. All bedrooms have good-sized windows, which allow plenty of natural light.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which</p>	<p>FA</p>	<p>St Joseph's Home of Compassion has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. A registered nurse is the designated infection control nurse with support from the care lead and all staff through the registered nurse meeting</p>

<p>minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>acting as the infection control team. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed yearly.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>A registered nurse is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (the registered nurses meeting) has good external support from the local laboratory and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the management team, the RN and IC coordinator and have been reviewed and updated.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training at the DHB. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</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</p>	CI	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Infections are</p>

<p>specified in the infection control programme.</p>		<p>part of the key performance indicators. Outcomes and actions are discussed at quality/staff meetings and registered nurse meetings. Benchmarking is undertaken with an external provider. Reports are easily accessible to the manager. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers.</p> <p>There was one resident using an enabler (a bedrail) and five residents with restraints (two bedrails, and three lap belts) during the audit.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (the senior registered nurse) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator, in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. Three hospital-level residents' files where restraint was in use were selected for review. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>

<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident and family and the GP. The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form, evidenced in three resident files where restraint was being used.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly and restraint use is discussed monthly at both registered nurse and staff/quality meetings. A review of three resident files identified that evaluations were up-to-date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>CI</p>	<p>The organisation and facility are proactive in minimising restraint usage. Restraints are monitored throughout each shift by clinical staff. Restraint numbers are collected each month and collated by our clinical committee bi-monthly. This data is also sent for benchmarking against other facilities across new Zealand and Australia.</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.

No data to display

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.3.2</p> <p>Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.</p>	CI	<p>The service provides services that are individualised and focus on dignity and respect. St Joseph’s provides an extensive pastoral care programme to ensure the needs of residents are met. Following feedback from resident’s staff and families, a number of initiatives have been implemented and exceed the required standard.</p>	<p>The Home employs a Pastoral Care Coordinator who works 20 hours a week as well as a Chaplain who is available to residents and families when needed seven days a week. The coordinator ensures that religious services are provided in-keeping with the service’s philosophy including; Mass - offered every day and the anointing of the sick is offered once a month, visiting Ministers from other religions are organised as needed, Ecumenical prayer services are offered every Friday, Anglican services offered monthly and as the need dictates.</p> <p>The pastoral care coordinator also visits with residents on a one-to-one basis and visits residents who are in the public</p>

			<p>hospital.</p> <p>Care of the deceased and their families includes when the funeral directors arrive to collect a deceased resident, staff, residents and families that are at the facility are invited to the entry/exit area to farewell the person. The Pastoral Care Coordinator attends funerals to support families and follows up with them after a few weeks to see if they need bereavement support. A card is sent on the first anniversary of a resident's death and this is very much appreciated from families. A memorial service is run every year and families are invited to attend. Families interviewed were very appreciative of the service and memorial services are very well attended.</p>
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	<p>CI</p>	<p>The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or</p>	<p>St Josephs provides examples of continuous improvement and have a goal to continually improve the service provided to residents and their families. Staff, families and management are encouraged to provide suggestions and ideas that could improve resident's lives. Ideas are actively sought at staff meetings.</p> <p>Examples include;.</p> <p>The service has an objective of improving communication for residents, families and the services. To assist this, the service has set up Wi-Fi set up in a small lounge for residents and families to use. Families interviewed were very positive regarding this initiative</p>

		resident satisfaction.	<p>The development of resident information pamphlet around pain management. Families and the residents have indicated that they now have a clearer idea of medication and treatment. They understand why a particular medication may be used and the likely changes that could occur in the future. This allows them to make a more informed decision on use of these medications.</p> <p>The development of a leadership programme for registered nurses. This in-depth programme has been attended by all the registered nurses. It was developed by the organisation following a review of adverse events and analysis of causes. The service reports that the registered nurses are using the skills they had learnt and were more confident in their dealings with the caregivers and with managing their roles. Link to falls reduction and pressure injury reduction – (1.2.3.6) and reduction in infections (3.5.7).</p> <p>As a result of the overall quality improvement initiatives at the facility already high survey outcomes continue.</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>There is a comprehensive quality and risk management process in place. Monitoring in each area is completed monthly, quarterly, six monthly or annually as designated by the internal auditing programme schedule.</p>	<p>The service is active in analysing data collected monthly, around accidents and incidents, infection control, restraint etc.</p> <p>Monthly recording of accidents and incidents from September 2015 showed an uncharacteristic upward trend in pressure injuries. This upward trend</p>

		<p>Audit summaries and action plans are completed as required depending on the result of the audit. Key issues are reported to the appropriate committee (eg, quality, staff, and an action plan) is identified. These were comprehensively addressed in meeting minutes sited.</p> <p>Benchmarking reports are generated throughout the year to review performance over a 12-month period.</p> <p>There is also a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. The service is proactive in developing and implementing quality initiatives. All meetings include excellent feedback on quality data where opportunities for improvement are identified</p>	<p>began in May 2015 with six pressure injuries recorded. Skin tears were noted to be high March 2015 (49 per occupied bed day), and falls high September 2015 (82 per occupied bed day).</p> <p>The service has consistently documented that these trends have been reported through the clinical team and because of this; strategies were put in place to try to reduce these.</p> <p>On evaluation of the effectiveness of these measures, they noted a drop in skin tears (down to 26 per occupied bed day March 2016 with a steadily reducing trend), falls (down to 65 per occupied bed day March 2016 with a steadily reducing trend and pressure injuries down to one PI, March 2016).</p> <p>The focus on the prevention and management of pressure injuries, skin tears and falls and the provision of additional training has been effective and the clinical practices are achieving successful outcomes for residents.</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>The service is proactive with monitoring all infections each month. Action plans put in place have ensured that the total infection rate continues to fall.</p>	<p>An increase in the number of infections, with a peak of 22 in July 2015, was identified through the monthly recording and reporting on infections by the Infection Control Coordinator. Discussions in the clinical team meetings identified reduction of infections as an area for focus. An action plan was implemented that included training and monitoring. Progress was monitored and discussed in the clinical</p>

			<p>team meetings.</p> <p>Figures have improved, with the lowest number of infections reported in 2016 (there were 9 in March and 10 in both January and April). Despite fluctuations in some categories, a sustained reduction has been achieved, even with more residents in the facility now that the new Aubert Wing is fully occupied.</p>
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>	CI	<p>The team at St Joseph's Home of Compassion remains committed to the principles of restraint minimisation. Since the last audit restraint numbers have trended downward, despite additional beds being added to the facility in May 2016.</p> <p>A restraint approval group meeting is held annually to discuss and amend the terms of reference for restraint use in the facility</p>	<p>The focus on minimising restraint included (but not limited to); providing ongoing restraint education in the form of presentations, handover talks and demonstration/teaching in real time by senior staff.</p> <p>Members of the MDT are also involved in restraint minimisation, for example recently a bedside that was used by a resident for bed mobility (enabler) was able to be discontinued after the physiotherapist worked with this resident to improve upper body strength and sitting balance. The physiotherapist and OT were then able to use an alternative option for bed mobility in the form of an overhead bar, which ended the need for restraint.</p> <p>Staff knowledge is assessed both through the completion of restraint competencies for all clinical staff, and regular audits assessing staff knowledge and the monitoring of restraint.</p> <p>Restraint minimisation education works hand in hand with education about falls prevention and management of</p>

			<p>challenging behaviour. Both of these topics have been the focus of education in the home and provide staff with knowledge and resources to use methods other than restraint to keep our residents safe.</p> <p>Restraints are monitored throughout each shift by clinical staff. Restraint numbers are collected each month and collated by the clinical committee bi-monthly. This data is also sent for benchmarking against other facilities across New Zealand and Australia. The benchmarking results indicate over time a decrease in restraint use from 11 in 2013 to 5 currently.</p>
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End of the report.