Home of St Barnabas Trust - Home of St Barnabas

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: Home of St Barnabas Trust

Premises audited: Home of St Barnabas

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 24 May 2018 End date: 25 May 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 39

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

The Home of St Barnabas Trust is a charitable trust under the Charitable Trust. The Trust is governed by a Board of Trustees that provide governance and direction. The home provides rest home level care for up to 41 residents. On the day of audit, there were 39 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with family, management, staff and the general practitioner.

The service is managed by an experienced manager that has been in the role for 20 years. She is supported by the senior management team and the trust board. The residents, relatives and general practitioner commented positively on the care and services provided.

Improvements are required around; Incident form follow-up, training for staff, the handover process, assessments, interventions and monitoring, and medication management.

Consumer rights

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

The Code of Health and Disability Services Consumer Rights pamphlets are available in the main entry and posters are on the walls throughout the facility. Policies are being implemented to support residents' rights. Assessment and care planning includes individual choice. The information pack provided to residents and their families includes the mission and philosophy. There is a Māori health plan to support practice and individual values are considered during care planning. There is a complaint's register and individual responses following a complaint are documented. Residents and family members and staff interviewed verified ongoing involvement with community groups and confirmed that the service is respectful and responsive to their needs, values and beliefs. An environment of open disclosure is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Home of St Barnabas has a current business plan, which includes a quality and risk management plan. The implemented quality programme includes regularly reviewed policies, an internal audit programme, analysis of quality data, and a health and safety programme that includes hazard management. Quality information is reported to facility meetings. Residents and relatives have

an opportunity to feedback on service delivery issues at the resident/family meetings and via annual satisfaction surveys. Incidents are documented and analysed as part of the quality data in monthly reports.

Human resource management policies are in place. There is online training offered to staff. The service has a documented rationale for determining staffing levels. Caregivers, residents, and family members report staffing levels are sufficient to meet resident needs.

Resident files are integrated, and care plans and notes are legible.

Continuum of service delivery

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

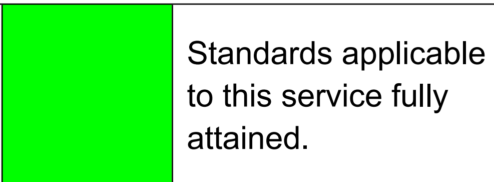
There is a comprehensive information package for residents/relatives on admission to the service. The registered nurses complete interRAI assessments, risk assessments, care plans and evaluations within the required timeframes. Residents and family members interviewed confirmed they were involved in the care plan process and review. Resident files include notes by the GP and allied health professionals. The general practitioner completes an admission assessment, visits and reviews the residents at least three-monthly.

A diversional therapist facilitates the activities programme. The programme is resident-focused and provides group and individual activities planned around everyday activities. Each resident has an individualised plan. Community activities are encouraged, and van outings are arranged on a regular basis.

There are medicine management policies and procedures in place that reflect legislative requirements. Medication is managed using an electronic medication management system. The medication charts are reviewed by the GP three-monthly. All staff responsible for administration of medicines had completed education and medication competencies.

A dietitian has reviewed the menu. Individual and special dietary needs are accommodated. Residents interviewed responded favourably to the food provided.

Safe and appropriate environment

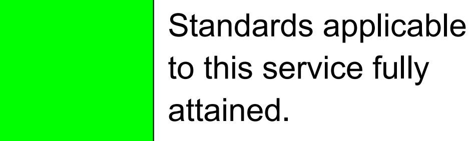
Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group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

The building has a current warrant of fitness. There are sufficient bathroom facilities to meet the needs of residents. Internal and external areas are safe and easily accessible for residents and family members.

The building, plant and equipment comply with legislation. There is a preventative maintenance schedule in place. There are waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals are stored safely throughout the facility and there is appropriate protective equipment and clothing for staff.

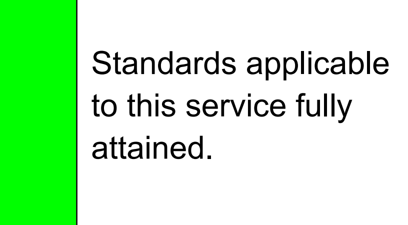
There are policies in place for emergency management. The facility has civil defence supplies. Alternative energy and utility sources are maintained, an appropriate call-bell system is available and security systems are in place. There is a person on duty at all times with first aid training. Housekeeping staff maintain a clean and tidy environment and implement effective laundry processes.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

There are policies around restraint, enablers and the management of challenging behaviours. The service is restraint free. There were no residents using enablers at the time of the audit. Policy dictates that enablers should be voluntary and the least restrictive option possible. The service has appropriate procedures, and documents for the safe assessment, planning, monitoring, and review of restraint and enablers should this be required.

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.

A registered nurse is the designated infection control coordinator and oversees the infection prevention and control programme. There is a quarterly combined quality/H&S/IC meeting and any relevant infection control issues are also reported at the monthly management meetings. The infection control coordinator can contact the DHB infection control nurse specialist or GP at any time for advice and information. The infection prevention and control policies are comprehensive. Infections are collated monthly and trends are identified and used to identify education needs or generate improvement in practice. Staff have annual infection control training and there are implemented internal audits around the environment and cleanliness that ensures that infection control is monitored.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	38	0	0	7	0	0
Criteria	0	86	0	0	7	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumer Rights. The service provides residents and family members with information on entry to the service and this information contains details relating to the Code. Staff receive training on the code at induction. Interviews with five caregivers, the care manager, the quality manager (registered nurse) and one diversional therapist (DT) demonstrated an understanding of the Code of Consumer Rights. Eight residents and five relatives interviewed confirmed that they were treated with respect and dignity.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Informed consent processes are discussed with residents and families on admission. Written general consents were included in the admission process as sighted in nine resident's files reviewed. Consent forms are signed for any specific procedures. Caregivers interviewed confirmed consent is obtained when assisting with care. Advance directives sampled identified the resident resuscitation status and/or signed by the resident (if appropriate) and the general practitioner. Copies of enduring power of attorney (EPOA) were seen in the resident files as appropriate.

		Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Admission agreements were sighted for the long-term residents.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information/admission packs include information in relation to advocacy services, including phone numbers and contact names being made accessible. The in-service programme includes orientation and ongoing training on advocacy, but this has not been undertaken by all staff recently (link 1.2.7.5). Staff interviewed demonstrated a good understanding of how residents can access advocacy service. Residents interviewed confirmed that advocacy support is available if required. The Chaplain is able to act in an advocacy role if required. Discussion with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions. The resident files reviewed included information on resident's family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The service has an open visiting policy. Family and friends are encouraged to visit the home and are not restricted to visiting times. Families interviewed confirmed that they could visit the home at times suitable to them. All residents interviewed confirmed that relatives and friends were able to visit at any time. Visitors were observed attending the home during the audit. The service has a van, and group and individual outings are provided. Community groups visit the home as part of the activities programme. Church services are provided at the home. Discussion with all staff, residents and relatives, confirmed that residents are supported and encouraged to remain involved in the community and external groups such as church.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy that complies with Right 10 of the Code. Residents and their families are provided with information on the complaints process on admission. Complaint forms are available at the main foyer. Staff interviewed were aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents and their families. Eight residents and five relatives interviewed, confirmed that they understand the complaints process. Five complaints were documented on the complaint register since the previous audit. Documentation reviewed identified that these were all followed-up and managed appropriately, within timeframes and with acknowledgement and response being documented when completed.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The resident rights policy includes roles and responsibilities. The Code of Health and Disability Services Consumer Rights pamphlets are available in the main entry and posters are on the walls throughout the facility. If necessary, staff will read and explain information to residents. Residents and relatives interviewed were able to describe their rights and advocacy services particularly in relation to the complaints process. The information pack provided to residents and their families on entry includes how to make a complaint, advocacy services and the Code of Rights.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code and include confidentiality and privacy policy. Staff interviewed, described the procedures for maintaining confidentiality of resident information, and employment agreements bind staff to retaining confidentiality of resident information. Discussions with residents and family members identified that care staff respect resident's privacy and that the service is respectful and responsive to their needs, values, and beliefs. All nine resident files reviewed identified individual preferences are identified. There is an abuse and neglect policy and a harassment policy that includes definitions and examples of abuse. Staff could describe definitions. Family members interviewed said that the care provided was very good. Not all staff have had recent training around abuse and neglect (link 1.2.7.5).
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The four cornerstones of Māori health care are included in the policy manual to support Māori residents. Cultural awareness education has not been undertaken by staff recently (link 1.2.7.5). The service has Māori staff members who act as resource people when required. The management described connections with Māori organisations. Residents care plans sampled identified the spiritual, religious and cultural needs of residents. There was one resident wo identified as Maori.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture,	FA	Family interviewed confirmed that they are encouraged to be involved in the care planning process. The service provides a culturally appropriate service by ensuring initial assessments fully capture

Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		resident's information regarding culture and beliefs. Care plans reviewed included the resident's social, spiritual, cultural, and recreational needs. There is a chapel at the facility. The Chaplain provides weekly services. Interviews with staff and residents identified that residents are able to access spiritual support of their preference. Residents who wish to attend their own church in the community are assisted to do so.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	There are policies and procedures to ensure that consumers are not subjected to discrimination, coercion, harassment, and sexual or other exploitation. There is comprehensive documentation and orientation to ensure that professional boundaries are maintained. The Code of Conduct covers discrimination, harassment, professional boundaries, and expectations. The quality and care managers described how they abide by their professional code of ethics.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Services are provided that adhere to the Health and Disability Sector Standards. Annual reviews of the quality programme and monthly reports from the manager to the board reflect the service's ongoing progress around quality improvement. The board has a detailed annual review where goals are reviewed. Policies and procedures cross-reference other policies and appropriate standards. All residents and families spoke positively about the care provided. There are implemented competencies for caregivers, and RNs. There are clear ethical and professional standards and boundaries within job descriptions.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an open disclosure policy, complaints policy and incident reporting policy. Twelve incident forms reviewed identified that family members have been notified for adverse events affecting their family members. Residents' meetings are held three monthly. The service has policies and procedures available for access to interpreter services. Interviews with staff confirmed knowledge around how to access interpreter services. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. Family members interviewed, reported they are kept informed when their family member's health status changes.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The Home of St Barnabas Trust was incorporated as a Charitable Trust under the Charitable Trusts Act 1957 in 2003, by the Anglican Diocese of Dunedin. The Trust is governed by a Board of Trustees that provide governance and direction. The home provides rest home level care for up to 41 residents. On the day of audit, there were 39 residents. Apart from one resident on respite care that was discharged on the first morning of the audit, all residents were funded under the aged residential care agreement. One resident had been assessed as hospital level care prior to the audit and was waiting to transfer to a hospital level facility. The manager reports monthly to the governing board and chair. Monthly senior management meetings occur, and meeting minutes demonstrated discussions around quality activities. These include the manager, the quality manager (RN) the care manager (RN) the kitchen supervisor and the house supervisor. The facility has a current business plan, which includes a quality and risk management plan. A quality management system includes gathering data and information to provide opportunities for quality improvement. The service is managed by an experienced manager that has been in the role for over 25 years. The manager has completed more than eight hours training related to her current role in the past 12 months. She is supported by the senior management team and the trust board.
Standard 1.2.2: Service Management 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 consumers.	FA	In the temporary absence of the manager, the manager’s role is held by two senior staff that are suitably qualified to undertake this role. Operational management decisions are made by the kitchen services manager. The quality and care managers provide clinical support.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects	FA	There is a business, quality, and risk management plan that includes aims and ambitions for the year 2018. Progress with the quality and risk management plan is monitored through the monthly senior management meetings, three monthly quality meetings, and three monthly general staff meetings. Minutes for meetings included actions to achieve compliance where relevant and these are available for staff to read. Quality meetings include discussion of audits, training, complaints, incidents and hazards, restraint, health and safety, infection control, food services, staffing and other general items.

continuous quality improvement principles.		Internal audits occur as documented in the audit planner and corrective actions were followed-up and signed off upon completion. The general manager reports to the board on a monthly basis and the report includes quality data and achievements that have been made over a month period. There are implemented health and safety (H&S) policies and procedures that comply with current health and safety legislation. The house supervisor is the identified health and safety representative and has completed H&S stage one and attends a H&S forum every year. The hazard manual was last updated in August 2017. Hazards are reported on accident and hazard forms and hazard identification forms are taken to quality meeting to discuss. Staff and resident accident/incident data, infection control data and restraint data are collected. Incident and accident investigation results (link 1.2.4.3) are discussed with staff through quality meetings, and staff meetings. A resident/family survey conducted in early 2018 was collated and analysed with pie graphs and review of comments. The survey identified that residents and families were very satisfied with the service. Survey outcomes were communicated to the residents and relatives through meetings. Falls prevention strategies are in place that include the analysis of falls incidents (link 1.3.6.1 and 1.2.4.3 for lack of post falls reviews and opportunities to minimise further risk).
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate	A review of 12 incident forms identified that they were completed by the staff member finding the incident and included an RN assessment. However, opportunities to minimise further risk were not documented at an individual level. Incident/accident and hazard data is collected. This data is analysed by the quality manager monthly across the service. Following analysis of the monthly data, quality improvements have been identified when required, and monitored by the quality manager. The manager, quality manager and the care manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Two notifications have been made regarding pressure injuries and one regarding a fracture.
Standard 1.2.7: Human Resource Management Human resource management	PA Moderate	There are human resource policies and procedures. All new staff receive an orientation programme and on-site support with a senior staff member. Eight staff files were reviewed (the care manager, the clinical manager, four caregivers, one

processes are conducted in accordance with good employment practice and meet the requirements of legislation.		diversional therapist and one kitchen supervisor), all included up-to-date documentation except training records. Relevant checks were completed to validate the individual's qualifications, experience and veracity. A copy of practicing certificates is maintained in the staff files. The service has an online staff training package, but caregivers and the care and quality managers interviewed, reported most staff members have not yet commenced this training. Additionally, there is a two-yearly education programme that covers contractual requirements. Attendance records are not always maintained, and attendances are reported as minimal. The purchase of the online package was intended to address this issue. The care manager and quality manager have participated in an external wound care study day. Staff who administer medication have current medication competencies that include warfarin and insulin management competency. Four caregivers interviewed confirmed that they have completed competencies at least yearly or earlier if required by the care manager following a medication error. Two RNs are interRAI trained.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a staffing policy that includes staff skill mix. The service maintains stable staffing and the manager described staff turnover as low. The manager (RN) works full-time. There are also two registered nurses (the care manager and quality manager) who both work five days per week and provide on-call. At the time of the audit these were 39 residents including one waiting for imminent transfer to hospital level care and one resident on respite care. On morning shift the caregiver roster is as follows: two staff on 6.15 am to 3.15 pm and two staff on 8.00 am to 1.00 pm. Afternoon shift is two staff on 2.45 pm to 11.15 pm and one staff on from 4.30 pm to 7.30 pm. There are two caregivers on night shift. Residents, family members and staff reported a high but manageable workload.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Resident files reviewed were integrated and included GP assessment and reviews. There is evidence of external health professional involvement where relevant. Care plans and notes reviewed were legible. Designation of the person who completed the entry documentation was recorded and dated. Clinical files are kept in the secure nurses' station.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when	FA	Entry processes are recorded and implemented. The facility information pack is available for residents and their family and contains all relevant information for rest home residents. The residents' admission agreements evidence resident and/or family and facility representative sign off. The admission agreement defines the scope of the service and includes all contractual requirements.

their need for services has been identified.		
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and coordinated manner. At the time of transition, appropriate information is supplied to the person/facility responsible for the ongoing management of the resident.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	The facility uses a computerised medication management system. On day two of the audit the staff were observed using paper-based medication charts, as the internet was down. The service has plans in place to manage such an issue and the staff followed the plans to ensure safe medication management on the day of audit. The registered nurses reconcile the blister packed medication against the individual resident electronic medication charts on delivery. Eighteen medication charts and signing sheets were reviewed and reflected medications were administered as prescribed. Medications have been reviewed three-monthly with medical reviews by the attending GP. All ‘as required’ (PRN) medications included reason for administration and efficacy documented. Resident photos and documented allergies or ‘nil known’ were documented on all medication charts reviewed. An annual medication administration competency was completed for all staff administrating medications and medication training had been conducted. There is a self-medicating resident’s policy and procedures in place. There were currently no residents who self-administered medications. Not all eye drops had been dated on opening and weekly medication checks had not always been documented. No vaccines were stored on-site.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals at St Barnabas are prepared and cooked on-site. The service has a large kitchen, which also provides meals for outside agencies such as meals on wheels. There is a food verification certificate ‘A’ grade and a food control plan expiring March 2019. There is a menu, which had been reviewed by a dietitian. The kitchen and food storage areas were observed to be clean, and all monitoring such as fridge, freezer and food temperatures have been documented. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are

		communicated to the kitchen. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a GP/dietitian. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service. The cook is part of the combined quality, health and safety meetings and is part of the management team. Fridge and freezer temperatures are monitored and recorded daily.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	A process to inform potential residents and family, in an appropriate manner, of the reasons why the service had been declined would be implemented, if required. The prospective residents would be declined entry if not within the scope of the service or if a bed was not available.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate	Initial assessments and reviews are evident in printed format in all resident files and included pressure area assessment, pain, mental health assessment, nutritional, gait and geriatric depression scale. Resident files reviewed identify that risk assessments are completed on admission and reviewed six monthly with the interRAI as part of the evaluation. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans. In the sample of nine resident files reviewed, risk assessments were evidenced to be completed on admission and reviewed six monthly, but were not always reviewed if there was a change in resident condition.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Nine resident files sampled all included a care plan and demonstrated service integration and input from allied health. There was evidence of resident (where able) and family consultation in the care planning process. Short-term care plans were not always in use for changes in health status. Care plans did not all reflect updated interventions to support recent changes to residents' health.
Standard 1.3.6: Service Delivery/Interventions	PA Moderate	If external nursing or allied health advice is required, the RNs will initiate a referral. Not all issues documented in progress notes or actions required by allied health are documented as followed up

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.		(link 1.3.3.4). Staff have access to sufficient medical supplies including dressings. Sufficient continence products are available and resident files sampled included a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Monitoring forms are in place for vital signs including weight, wounds, behaviour management, and food and pain management (link 1.3.3.4). A post-falls review as not been completed as per policy for residents following falls. Wound documentation is available and includes assessments, management plans, progress and evaluations. All wound documentation reviewed was fully completed and wound care was evidenced to be occurring within the prescribed timeframes.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There is a diversional therapist employed, who works 35 hours per week, Monday – Friday. Activities are provided for each morning and afternoon from Monday to Friday. The programme is developed monthly. Each resident has an individual activities assessment on admission and from this information, an individual activities plan has been developed by the activities staff for the resident files sampled. The activities programme reflects the residents' cognitive and physical abilities. Group activities reflect ordinary patterns of life and include planned visits to the community. There are weekly happy hours and local entertainers visit and entertain residents. Residents and families interviewed commented that activities meet resident needs. During the audit, residents were viewed enjoying activities with the DT. There are resident meetings, where residents are part of planning activities for the next month. Church services are provided on a regular basis. Mass is held monthly. Residents interviewed spoke positively about the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans are evaluated by the registered nurses within three weeks of admission. The long-term care plan is reviewed at least six-monthly. Evaluations reviewed document progress toward goals. There is at least a three-monthly review by the GP. Care plan reviews are signed by an RN. Changes to resident health status is not always updated in the care plans (link 1.3.5.2).
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)	FA	If the need for other non-urgent services is indicated or requested, the GP sends a referral to seek specialist service provider assistance. Acute/urgent referrals are attended to immediately, sending the resident by ambulance if the circumstances dictate. Residents are supported to access or seek referral to other health and/or disability service providers. Following discussion with the GP, RNs

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		refer to a dietitian, speech language therapist, and mental health nurse practitioner.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes are in place for the management of waste and hazardous substances. Interview with the administration manager whose role includes maintenance, confirmed there is safe storage and safe use of chemicals. There was evidence that chemicals are correctly labelled and securely stored. Material safety datasheets are available and accessible for staff. Protective clothing and equipment that is appropriate to the recognised risks associated with waste or hazardous substance being handled, is available. Staff were using protective clothing and equipment on audit days. Cleaners keep chemicals with them at all times when in use.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current warrant of fitness. All hoists, medical equipment and weigh scales have been calibrated, tagged and tested. There is a preventative maintenance schedule in place. Hot water temperatures are checked monthly and are within safe parameters. If there are concerns, corrective actions are implemented. Outdoor areas are easily accessible for residents.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are a number of ensuite rooms in the rest home as well as rooms with shared ensuites and also standard rooms. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. There are an adequate number of accessible showers, toilets and hand basins for residents. Bathrooms have appropriately secured and approved handrails, along with other equipment/accessories that are required to promote resident independence. Toilets and showers are of an appropriate design with adequate space for mobility aids. Residents interviewed reported their privacy is respected at all times.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas	FA	All resident rooms are personalised to individual taste. Each room is spacious with adequate space for residents to move around freely with mobility aids.

appropriate to the consumer group and setting.		
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Adequate access is provided to lounges and dining areas in each unit. Residents were observed moving freely within these areas. There are quiet seating areas for residents to use with family. The furniture is appropriate to the setting and arranged in a manner that enables residents to mobilise freely.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry staff with assistance from care staff manage the laundry duties. A laundry person is employed in the mornings and is responsible for the overall management of the laundry, including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents. There is a designated dirty to clean flow. Staff cleaning, and laundry policies and procedures are available. Cleaners undertake the cleaning requirements. The effectiveness of the cleaning and laundry services is audited via the internal audit programme. Chemicals are stored and labelled according to legislation.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergencies, first aid, and CPR are included in the mandatory in-service programme, however, emergency training attendance cannot be verified (link 1.2.7.5). There is a first aid trained staff member on every shift. There is an approved fire evacuation plan and fire drills occur six monthly. Emergency lighting is in place. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (BBQ) available in the event of a power failure. There are civil defence kits in the facility and stored water. Call bells are evident in resident’s rooms, lounge areas, and toilets/bathrooms. The facility is secured at night.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that	FA	All resident rooms have external windows. The environment is maintained at a safe and comfortable temperature.

is maintained at a safe and comfortable temperature.		
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Home of St Barnabas has an infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. There is an infection control policy and procedure manual which is readily accessible to all staff. Infection control (IC) is a standing agenda item at the quality meetings and staff meetings where all issues and infections are discussed with staff. All results and IC concerns are reported to the manager on a monthly basis or sooner if there is an issue. The infection control coordinator collates a monthly record of infections data and provides a report to the quality meetings. RNs are also involved in prevention and management of IC activities. The IC nurse and the resident's general practitioner are notified promptly of any positive pathology that is identified as an infection. Any notifiable disease or serious outbreaks are notified to the appropriate authorities. A RN is always available for emergent issues.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IC nurse is the care manager and is responsible for infection control and prevention and collection of surveillance data. She had completed a level seven IC management paper and receives regular updates from IC & P Nurses College. The IC nurse described how to access external support from the experts, the IC specialist team through the local DHB and the public health services.
Standard 3.3: Policies and procedures 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.	FA	The IC programme outlines a comprehensive range of policies, standards, and guidelines and include defining roles, responsibilities and oversight, the infection control team, training and education of staff. IC policies and procedures are developed and updated by the care manager. Any changes or updates to the infection control policies are discussed at quality and staff meetings.

Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The IC nurse has completed a level seven infection control management paper and receives regular updates from Infection Control and Prevention Nurses College. All staff receive IC education at orientation. Food services and housekeeping staff receive IC education relevant to their areas (link 1.2.7.5). IC is included in the annual in-service training programme. Online training programme includes IC training (link 1.2.7.5). Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Internal monitoring is also undertaken via the internal audit programme - 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. Outcomes and actions are discussed at the senior management meetings, quality meetings, and three-monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around restraint, enablers and the management of challenging behaviours. The service is restraint-free. There are no residents using enablers. Policy dictates that enablers should be voluntary and the least restrictive option possible. Restraint/enabler use, and restraint minimisation are discussed at senior management meetings, at staff meetings and at the three-monthly quality meetings. Staff have not all received training around restraint minimisation and safe practice (link 1.2.7.5).

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	**Attainment Rating**	**Audit Evidence**	**Audit Finding**	**Corrective action required and timeframe for completion (days)**
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	When an incident occurs, the caregivers complete an incident form. The incident forms are then followed up and signed off by the quality manager and care manager. However, not all incident forms had been fully completed to evidence follow-up and sign -out (link 1.3.6.1).	Six of 12 incident forms did not have an opportunity to minimise further risk documented.	Ensure all incidents are reviewed for opportunities to minimise further risk. 60 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and	PA Moderate	Since the previous audit the service has purchased an online training package that provides modules to cover all required caregiver	Staff report zero to four people attend in-service training. Training has been scheduled as provided via on line training	Ensure all staff complete required

record ongoing education for service providers to provide safe and effective services to consumers.		training. However, it is reported that most caregivers have not yet attended this. In-service training is also provided, however, there are very few records of attendance. Staff reported minimal attendance.	but there is zero attendance at most sessions; eg. Privacy and dignity, restraint, falls prevention, advocacy, and elder abuse	training. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	The service has policies and procedures in place to safely manage medications for residents. All medications are stored in the secure nurses' station. Two medication trolleys are secured to the wall when not in use.	Three opened bottles of eye drops had not been dated, and weekly controlled medication checks had been missed on two occasions in the controlled medication book.	Ensure that eye drops are dated on opening and weekly controlled medication checks are documented as per policy. 30 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Moderate	There is a documented handover between all shifts and progress notes are written by the caregivers every shift. RNs do not attend all handovers and handover documents do not always include all changes to care. Not all issues documented in progress notes or actions required by allied health are documented as followed up.	(i)Caregivers follow the care plan and report progress against the care plan each shift at handover. However, RNs do not routinely attend handover and are not always informed of resident changes. The handover document does not include all changes to care needs. (ii) Registered nurse described how they follow-up of identified issues. However, instructions from allied health professionals have not been consistently documented and followed through, including; (a) Following a period of possible dehydration, the fluid chart was implemented but was not followed	Ensure that the resident needs are communicated to all care staff and that RNs are aware of current resident needs and changes in health status.

			through by care staff, (b) monthly review of mental health status as required by the mental health team for one resident, (c) weekly reviews of care in the progress notes, as required by the service for two residents.	30 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	Nine resident care plans were reviewed for this audit, seven as the sample and two additional files for residents identified by caregivers as very high needs. The two residents' files were reviewed; both had high needs, one was no longer able to walk, was resistant to care and had a history of aggression. The second resident's progress notes document a wandering risk, a risk of falls due to an unsteady gait and pain issues. One of the two residents who have been identified as high needs have not had an RN recent review/reassessment or reassessed of all current care needs.	One of two residents who have been identified as high needs have not had an RN recent review/reassessment or reassessed of all current care needs. One resident did not have an interRAI reassessment completed following change of health status.	Ensure that residents with a change of care needs have a documented RN assessment and (if needed) and interRAI assessment. 30 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	The RNs are responsible for all resident assessment and care planning. All residents had an up-to-date interRAI in place and a care plan documented. The interventions documented did not reflect all resident current needs. Caregivers interviewed, were knowledgeable regarding resident needs.	Three of nine care plans had not been updated to reflect care needs and/or did not reflect individualised care needs. This included; (i) One resident file documented care of wounds, however there were no current wounds. (ii) One resident did not have the risks associated with warfarin in their care plan. The care plan referred to care of wounds. The resident has no current wounds. (iii) One resident's care plan had not been updated to reflect high falls risk.	Ensure that care plans document the individualised care needs for each resident. 60 days

Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Caregivers interviewed were very knowledgeable regarding resident care needs. Families and the GP commented positively of the care provided to residents. The service has policy and procedures and templates to ensure that care can be safely managed, monitored and documented. A post-falls review as not been completed as per policy for residents following falls.	Nine of nine falls-related incident forms reviewed did not document a post falls review as per policy.	Ensure that fall reviews are documented as per service policy. 30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.