# St Johns Hill Healthcare Limited - St Johns Hill Healthcare

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** St Johns Hill Healthcare Limited

**Premises audited:** St Johns Hill Healthcare

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 14 November 2019 End date: 14 November 2019

**Proposed changes to current services (if any):** Build an extension onto the existing facility consisting of 44 beds (20 dementia and 24 hospital level) with associated facilities, including a new kitchen. It is envisaged that work will start early 2020 and will be completed in stages with a new kitchen being stage one.

The request by HealthCERT relating to the reconfiguration completed in 2018 to increase the bed numbers from 56 to 60 is included in this report.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 56

# 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** |
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|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

St Johns Hill Healthcare provides rest home and hospital level care for up to 60 residents. The service is operated by St Johns Hill Healthcare Limited and is privately owned. A general manager oversees operations, and a facility manager and a clinical manager manage the day to day operations of the service. Residents and family/whānau spoke positively about the care provided.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family members, the managers, staff, a general practitioner and a physiotherapist.

A storage room and toilet on both floors were converted into a double bedroom with an ensuite in 2018 and resulted in an increase of bed numbers from 56 to 60.

Continuous improvement ratings have been awarded for the management of quality improvement data and the reduction of residents’ falls.

The required improvement from the previous audit relating to aspects of residents’ information documented in clinical notes is closed. There are no areas requiring improvement from this audit.

## Consumer rights

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| 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. |

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There is access to interpreter services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

The facility manager is responsible for the management of complaints and a complaints register is maintained. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

## Organisational management

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| 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. |

St Johns Hill Healthcare Limited is the governing body and is responsible for the services provided. Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse. The facility manager is supported by a clinical manager and a general manager who are both registered nurses.

The management of quality and risk is a strength of the service. Systems are fully implemented and documented for monitoring the services provided, including regular reporting by the general manager to the owner/director.

Quality data is collected, collated and analysed to identify trends that leads to improvements. Continuous improvement occurs using an electronic data collection system that enables effective reporting and monitoring. All staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

There is an internal audit programme in place. Adverse events are documented on accident/incident forms. Corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Quality, health and safety, management, various staff and residents’ meetings are held on a regular basis.

Policies and procedures on human resources management are in place and processes are followed. The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents. Registered nurses are rostered on duty at all times. The clinical manager and facility manager are rostered on call after hours.

## Continuum of service delivery

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| 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. |

Residents’ needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents’ files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

## Safe and appropriate environment

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| 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. |

A current building warrant of fitness was displayed. Due to the reconfiguration, structural alterations have occurred since the previous audit.

## Restraint minimisation and safe practice

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| 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. |

The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were no residents using a restraint or an enabler at the time of audit.

## Infection prevention and control

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| 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. |

Aged care specific infection surveillance is undertaken, data is analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## Summary of attainment

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

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| **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 | 17 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 2 | 38 | 0 | 0 | 0 | 0 | 0 |

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| **Attainment Rating** | **Unattained Negligible Risk****(UA Negligible)** | **Unattained Low Risk****(UA Low)** | **Unattained Moderate Risk****(UA Moderate)** | **Unattained High Risk****(UA High)** | **Unattained Critical Risk****(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers’ Rights (the Code). The information is provided to residents and families on admission and complaints information and forms are available at the main entrance. There have been 27 complaints for 2018 and 2019 and these have been entered into the complaints register. Complaint documentation was reviewed and actions taken were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible. The FM is responsible for complaint management and follow-up. Staff interviewed confirmed a sound understanding of the complaints process and what actions are required.The FM reported there have been no complaint investigations by external agencies since the previous audit. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and families stated they are kept well informed about any changes to their own or their relative’s status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services can be accessed via the local DHB if required. The facility manager (FM) advised there are currently no residents who require an interpreter.Observation by the auditors evidenced effective communication and interaction between staff, residents and families. Residents and families confirmed this. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | A business plan includes business strategies and outlines organisational values, a philosophy, mission statement, scope, direction and goals of the organisation. The documents described annual and longer-term objectives and the associated operational plans. An organisational chart and responsibilities of the senior management team is included. The general manager (GM) reported they have daily contact with the owner/director and meet at least two monthly to discuss all activities. Minutes of meetings reviewed confirmed this. The service is managed by an experienced facility manager with oversight by a general manager, both are RNs. The FM has been in the role for six years when the facility opened and is supported by the GM and clinical manager (CM). Responsibilities and accountabilities are defined in their job descriptions and individual employment agreements. Both the GM and FM confirmed a sound knowledge of the sector, regulatory and reporting requirements and maintain currency through their nursing registration and involvement in the sector. Management meetings between the three senior managers are held two monthly and a wide range of activities are discussed; review of minutes confirmed this. The service holds contracts with the DHB for hospital level care, rest home, intermediate care respite and chronic medical conditions. Twenty-three residents were receiving services under the hospital level care contract, 32 under the rest home care contract and one resident under the intermediate contract at the time of audit. All rooms are dual purpose. The FM reported hospital level residents are accommodated on the ground floor and rest home level residents on the first floor, apart from one hospital level resident who resides on the first floor. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The planned quality and risk system reflects the principles of continuous quality improvement. This includes internal audits, annual resident and family satisfaction surveys, incidents/accidents, complaints, clinical incidents including infections, monitoring of outcomes and regular risk register review and risk mitigation strategies. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the senior management meetings, RN/quality meetings and the overall staff meeting. Staff confirmed their involvement in quality and risk management activities through incident reporting, audit activities, hazard identification and meeting attendance. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent surveys for November/December 2018 evidenced high satisfaction with services provided for both families and residents. The FM reported the 2019 surveys are due to be sent out.Policies and procedures are relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Policies are reviewed at least annually and were current. Obsolete policies are archived electronically. Staff are notified via the staff meetings of reviewed updated/new policies and these are discussed. The FM stated new/reviewed policies are held electronically and provided in hard copy for staff to read, in the staff room. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for service delivery. The FM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The facility manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. Information and quality data is shared openly and corrective actions developed collaboratively at every level of the organisation. Opportunities for improvement are pursued by residents, families, staff, and managers alike and evaluation of all aspects of residents’ well-being occurs to ensure quality safe care. Staff at all levels demonstrated a sound knowledge of all quality activities. An electronic quality data system is used for data reporting, analysis and sharing of data and complements the services quality system in place. The continuous improvement rating from the previous audit has been maintained. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | Adverse, unplanned or untoward events are reported to the RN on duty or the FM and entered into the electronic system. A monthly adverse events summary is generated, one for each level of care. The summary includes possible contributing factors identified, areas where the event occurred and what shift, and preventive or corrective measures identified. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. Residents’ files evidenced communication with families following adverse events involving the resident, or any change in the resident’s health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative’s condition.Policy and procedures comply with essential notification reporting. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. The FM interviewed and review of documentation evidenced there have been two section 31 notifications for 2018 and five for 2019 notified to HealthCERT since the previous audit.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.The orientation for caregivers is the equivalent of Careerforce, level two. New caregivers are orientated by a senior caregiver who works alongside them as an initial ‘buddy’ and undertakes reviews of the caregiver’s progress. The senior caregiver acts as an ongoing mentor to provide support and guidance. The CM is responsible for the orientation of new RNs. Orientation for staff covers all essential components of the service provided.In-service education is provided for staff at least monthly that covers all required topics. Review of the programme for 2019 and attendance records evidenced good attendance at all sessions. Training is also discussed at ‘toolbox talks’ at handover, includes specific topics relating to a resident’s health status and during staff meetings. Outside educators take sessions and RNs attend sessions at the local DHB. Competencies were current including medication management and restraint. Of the eight RNs, five are interRAI trained and have current competencies. There is at least one staff member on each shift with a current first aid certificate.A New Zealand Qualification Authority education programme (Careerforce) is available for staff to complete and they are encouraged to do so. The FM is the Careerforce assessor and care staff have attained level two, three and four. Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals. |
| 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 documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery. Staffing levels are reviewed constantly to meet the changing needs of residents and the layout of the physical environment. The FM and CM share on-call week about and this information is kept in the nurses’ station for staff. Care staff reported there is adequate staff available to complete the work allocated to them. Residents and families interviewed confirmed this. Observations and review of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. The FM reported there is also flexi shifts where caregivers are able to work longer hours should there be a need where a change in residents’ health status requires this. Staff who have current aid certificated are identified on the rosters. The senior managers are all experienced RNs and the eight RNs on the floor have all prior aged care experience and have been employed in the service from one to six years. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident’s name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents’ information sighted. The previous audit requiring corrective action to be taken regarding forms related to residents’ care and environment recordings not always being fully or accurately recorded, has been addressed. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted included the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP reviews were consistently recorded on the electronic medicine chart. There were three residents who self-administer medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner. Medication errors are reported to the RN, the clinical nurse leader (CNL) and facility manager (FM) and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors. Management of a previous and recurring medication error event was reviewed and evidence sighted of actions taken. Compliance with the process for managing medication errors at St Johns Hill Healthcare was verified. Standing orders are not used. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian June 2019. Recommendations made at that time have been implemented. A food control plan is in place and registered with the Whanganui District Council. A verification audit was undertaken on 23 January 2019. No areas requiring corrective action were identified.All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident’s nutritional needs was available.Evidence of resident satisfaction with meals was verified by residents and family interviews, satisfaction surveys and residents’ meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There was enough staff on duty in the dining rooms at mealtimes to ensure appropriate assistance was available to residents as needed. An interview with the cook evidenced the use of shape moulds to shape pureed meals is no longer occurring, as per the residents’ request. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the care provided to residents of St Johns Hill Healthcare was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. An initiative aimed at analysing and addressing the high number of falls rest home residents were having in their bedrooms has resulted in a reduction in falls and is recognised as an area of continuous improvement. An ongoing initiative to analyse and reduce the number of pressure injuries, remains ongoing as this has not been running long enough to evaluate the effectiveness of the initiative. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned ActivitiesWhere 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 | The activities programme is provided by a trained diversional therapist and two recreation assistants. A recreation programme is provided seven days a week. Five days a week separate programmes run in each of the rest home and the hospital. Residents can attend as they wish.A social assessment and history are undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated regularly and as part of the formal six-monthly care plan review. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents’ goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included van outings, pet therapy, visiting entertainers, quiz sessions and daily news updates. The activities programme is discussed at the residents’ meetings and minutes indicated residents’ input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents’ needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans were consistently reviewed for infections, pain and weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed that expires on the 17 June 2020. A code compliance certificate dated 17 August 2018 has been issued by the local authority and an email from the New Zealand Fire Service confirmed the current fire evacuation scheme remains approved following the alterations.A storage room and toilet on both the ground floor and first floor have been converted into a double bedroom and ensuite (rooms 43 and 147). The FM reported the rooms are for single residents or couples only. Both rooms were occupied during the audit with a couple residing in one and one resident in the other.The bedrooms are large with good space for equipment and staff to manage care and are fit for purpose. Call bells and bed lights have been installed to accommodate two people. Appropriate heating was sighted. Although the FM reported the rooms are not for use by two people who do not know each other, provision of privacy is available should the policy change. The facility also has portable screens that can be used if privacy is required for one or other of a couple. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident’s clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The infection control co-ordinator (ICC), CNL and FM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered into an external advisor’s electronic infection database. Data is benchmarked nationally with other aged care providers. Evidence verified infection rates are low. An initiative is in place around the implementation of a training programme to ensure competencies in catheterising residents. This however had not been written up or evaluated at the time of audit.A norovirus outbreak in July 2019 was evidenced to be managed appropriately and well contained. A respiratory outbreak in July 2019, saw several residents admitted to the WDHB. A section 31 notification was made to the Ministry of Health (MOH).Adequate supplies of equipment are available to manage outbreaks at St Johns Hill Healthcare.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers. The restraint coordinator is the FM and demonstrated a sound understanding of the organisation’s policies, procedures and practice and their role and responsibilities. The facility maintains a restraint free environment and there were no residents using an enabler. Residents are monitored closely, and equipment is in use so that restraints are not required. Regular training and competencies occur for staff on restraint minimisation and safe practice and staff interviewed demonstrated good knowledge. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | Continuous improvement is a strength of the organisation and was evident throughout the functions of all resident, staff, management and governance meetings. Information and quality data are shared openly and corrective actions developed collaboratively at every level of the organisation. Opportunities for improvement are pursued by residents, families, staff, and managers alike and evaluation of all aspects of residents’ well-being occurs to ensure quality safe care. Following the collection of quality data and the comprehensive analysis and evaluation to identify trends, a number of quality initiatives have been identified including but not limited to reducing the number of resident falls and with a pressure injury initiative recently implemented. The annual performance improvement assessment tool documents the improvements for the year and the initiatives planned. An electronic quality data system is used for data reporting, analysis and sharing of data and complements the organisation’s quality system in place. The continuous improvement rating from the previous audit has been maintained.  | The documented evaluation process includes comprehensive analysis and reporting of findings to management and staff. The continuous improvement rating from the previous audit has been maintained. Documentation evidenced action taken based on findings and improvements to the system. Staff and resident satisfaction with the reporting of quality data forms part of the evaluation process and continues to be measured. Residents and families reported satisfaction with the quality of the data being shared and improvements made. |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | CI | An analysis of every fall event identified several contributing factors that were evident in falls occurring for rest home residents. These related to the sensor mats on high risk residents not always being plugged in and active, residents falling when they were trying to pull their curtains closed when it got dark and residents getting their feet caught up in the valances on their beds. In addition to poor footwear, causative factors for falling also included not using mobility aids, items falling over in the room causing a trip hazard and residents not waiting for assistance from the nurse.Falls prevention training was implemented for staff. Residents were encouraged to attend the exercise classes. All residents with sensor mats have these checked to ensure they are plugged in at the beginning and end of each shift and this is signed off by the resident’s nurse. If a resident’s footwear is not appropriate, family members are advised if and when new footwear is required. Staff check the resident’s footwear before the resident mobilises each morning. Rooms are left clutter free after attending to the resident’s care. Staff pull residents’ curtains in the late afternoon and remove the valances on residents’ beds. The focus on falls has made everyone aware of attending to things promptly to mitigate the falls risk and has significantly reduced the numbers of falls. | An initiative to reduce the number of rest home residents falling in their bedrooms has resulted in a 75% reduction in falls between 1 August 2019 and 30 September 2019. |

End of the report.