# St Johns Hill Healthcare Limited - St Johns Hill Healthcare

## 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 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: 29 June 2021 End date: 30 June 2021

**Proposed changes to current services (if any):** The proposed rebuild of the kitchen and new build of a 24-bed hospital wing and a 20-bed dementia unit included in the previous audit report has been put on hold.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 58

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

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

## General overview of the audit

St Johns Hill Healthcare provides hospital and rest home 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 nurse leader manage the day-to-day operations of the service. Residents and family/whānau were complementary about the care provided.

This certification 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, families, managers, the owner/director, staff and a general practitioner.

Continuous improvement ratings have been awarded relating to a reduction in pressures injuries, a restraint free environment and the continuation of the management of quality improvement data. 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. |

St Johns Hill Healthcare ensures the Health and Disability Commissioner’s Code of Health, and Disability Services Consumers’ Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

The facility provides services in a manner that respect the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

St Johns Hill Healthcare has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

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. The governance, business strategy and quality and risk management plans include the scope, direction, goals, values, mission statement and philosophy of the organisation. An organisation chart sets out the structure. 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 nurse leader and the 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 to all levels of the organisation, including 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 by the external consultant. Quality, health and safety, management, various staff and residents’ and family 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 is a strength of the service and ensures safe service delivery.

Staffing levels and skill mix meet the changing needs of residents. Registered nurses are rostered on duty at all times. The clinical nurse leader and facility manager are rostered on call after hours.

Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents’ records are maintained using integrated electronic and hard copy files.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

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 arise. All residents’ files reviewed demonstrated that needs, goals, and outcomes are identified and reviewed on a regular basis. Residents and their family members when interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and two activities coordinators, seven days a week. The programme 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 is displayed at the front entrance. The preventative and reactive maintenance programmes are robust and include equipment and electrical checks.

There is a mix of rooms with individual and shared full ensuites. Adequate numbers of additional bathrooms and toilets are available. Several lounges, dining areas and alcoves are available. External areas provide seating and shade.

An appropriate call bell system is available, and residents reported timely responses to call bells. Security and emergency systems are in place. Staff are trained in emergency procedures and emergency resources are readily available. Supplies are checked regularly. Fire evacuation procedures are held six monthly.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is undertaken on site and cleaning and laundry processes are evaluated for effectiveness.

## 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 enablers at the time of audit. St Johns Hill Healthcare is a restraint free environment and has not used restraint since 2014.

## 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. |

The infection prevention and control programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent, and manage infections. Specialist infection prevention and control advice is accessed from Public Health and the Whanganui District Health Board. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

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.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 3 | 90 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | St Johns Hill Healthcare (St Johns) has policies, procedures, and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| 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 | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent form including for photographs, outings, invasive procedures, and collection of health information. Residents’ meeting minutes included mention of residents being reminded that they have a right to be fully informed and given all information before making a choice about commencing a treatment.  Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident’s file. Staff demonstrated their understanding by being able to explain situations when this may occur.  Staff were observed to gain consent for day-to-day care on an ongoing basis. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Brochures related to the Advocacy Service were also accessible throughout the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Staff were aware of how to access the Advocacy Service. |
| 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 | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.  The facility has unrestricted visiting hours and encourages visits from residents’ families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| 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. The information is provided to residents and families on admission and complaints information and forms are available at the main entrance.  Twelve complaints have been received in the last year 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 facility manager (FM) is responsible for complaint management and follow-up. Staff interviewed confirmed a sound understanding of the complaints process and what actions are required.  There have been no complaint investigations by external agencies since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents and family members of residents when interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and in discussion with staff. The Code is displayed in a range of locations around the facility. Brochures on the Code, the advocacy service, how to make a complaint and feedback forms, were also accessible throughout the facility.  Resident and family meeting minutes included details of discussion around the value of complaints and how to go about making one. All residents and family members interviewed verified they found management easy to approach and would make a complaint if the need arose. One family member mentioned a prompt response by management in addressing a concern. |
| 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 | Residents and family members of residents confirmed services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.  Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and during discussion with families and the General Practitioner (GP). There is one double room, able to be used by a couple. At present this is occupied by a single resident. All other rooms are single. Signage at the front entrance informs everyone entering that ‘CCTV’ surveillance cameras are operating in the building.  Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest. In the past, residents had participated in clubs of their choosing, however the present residents have no desire to do so at this time. Each resident’s care plan included documentation related to the resident’s abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training. |
| 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 | There is one resident in St Johns at the time of audit who identifies as Māori. Documentation, observations, and interviews verify staff are able support the resident to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers at Whanganui District Health Board (WDHB). |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents and residents’ family members verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident’s personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes, spiritual needs, and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met, and this supported those individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and their family members when interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A GP also expressed satisfaction with the standard of services provided to residents.  The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, wound care specialist, community dieticians, speech language therapist and mental health services for older persons, and access to ongoing education for staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  The training programme is a strength of the organisation (refer Standard 1.2.7). Staff reported they receive management support to attend in-services, external education, and access to their own professional networks, such as on-line forums, to support contemporary good practice.  Other examples of good practice observed during the audit included a commitment to reducing the number of pressure injuries. This is an area identified as one of continuous improvement. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their own or their relative’s status, 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 WDHB when required. Staff reported interpreter services were rarely required due to all present residents being able to speak English. |
| 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 governance plan includes the organisational values, philosophy and a mission statement, responsibilities and potential risks. The business strategy 2020/2021 includes but is not limited to the aims of the organisation, a monitoring plan, human resources and external relationships. An organisational chart sets out responsibilities of the senior management team. The general manager (GM) reported they have daily contact with the owner/director who is on site and that they meet at least monthly to discuss all activities. Minutes of meetings reviewed confirmed this.  The service is managed by an experienced facility manager with operational support by a general manager, both the GM and FM are RNs. The FM has been in the role for approximately seven years when the facility opened and is supported by the GM and clinical nurse leader (CNL). The CNL started in the role in October 2020. Prior to starting as the CNL, they were an RN on the floor. 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 managers and a wide range of activities are discussed. Interviews and review of minutes confirmed this. The change of CNL has been notified to HealthCERT. Documentation confirmed this.  The service has contracts with the DHB for hospital, rest home, intermediate care respite and chronic medical conditions. Twenty-four hospital and 32 rest home level residents are under the residential contract, one resident at hospital level is under the intermediate contract and one hospital level resident is under the chronic health contract. All rooms are dual purpose. The FM reported hospital level residents are mainly accommodated on the ground floor and rest home level residents on the first floor. |
| 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 | The FM advised that if they are absent, the CNL would fill the position with support from a senior RN who was in the position of CNL. If the CNL was absent the senior RN would fill the roll with support from the FM. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The continuous improvement rating from the previous audit has been maintained. The quality assurance and risk management policy includes a framework with goals and objectives. 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, a restraint free environment, clinical indicators 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 general staff meeting. Staff confirmed their involvement in quality and risk management activities through incident reporting, audit activities, hazard identification and meeting attendance. Corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The family survey of January/February 2021 and the resident survey of March/April 2021 evidenced a high level of satisfaction.  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 by the external consultant and are current. The FM stated that if they want a specific policy, the consultant develops one. 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 staff access them online. 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. A risk register/hazard register is reviewed by the FM six monthly and documents actual and potential risks/hazards. The facility manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The health and safety committee members and the kitchen and housekeeping staff have all completed level one unit standards 497 and all staff will eventually complete the training.  Continuous improvement is a strength and focus of the service and this was evident throughout the activities and functions of all residents, family, staff, management and governance meetings. Information and quality data continues to be shared openly and corrective actions developed collaboratively at every level of the organisation. 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. |
| 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 entered into the electronic system and given a risk rating. The FM reported they may change the level of risk if required. Each level has a description to assist staff to decide which level should be entered when reporting. The FM checks all incident reports daily. Any that are rated high and above are alerted automatically on the FM’s cell phone. Documentation reviewed included a register of all incidents and accidents. A monthly adverse events summary is generated, one for each level of care. The summary includes possible contributing factors identified, areas the event occurred and what shift, and preventive or corrective measures identified. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. Documentation pertaining to the incident is scanned into the electronic system (eg, urological observations and photos of skin tears).  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 has been a section 31 notified to HealthCERT since the previous audit relating to an influenza outbreak. |
| 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, police vetting and visas, where required.  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 CNL and senior RNs are responsible for the orientation of new RNs. Orientation for staff covers all essential components of the service provided.  In-service education is a focus and strength of the organisation. Ongoing training is provided at least two weekly that covers all required topics. Review of the programme for 2020 and 2021 and attendance records evidenced good attendance at all sessions. Training is also discussed at ‘toolbox talks’ at handover, specific topics relating to resident’s health status and during staff meetings. Caregivers confirmed that the RNs undertake one to one training during the shifts. Outside educators take sessions and RNs attend sessions at the local DHB. Competencies were current and included, but were not limited to medication management, restraint, manual handling, syringe driver management and hand hygiene. Of the eight RNs, four are interRAI trained, plus the CNL and have current competencies. Two RNs are booked to complete the training. 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 and senior caregiver who runs the programme are the Careerforce assessors. Ten caregivers have attained level 3 and six are currently completing the course. Four caregivers have attained level 4 and six are currently completing the course.  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 | The annual leave and rostering policy documents the rationale that determines 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 CNL work full time Monday to Friday and are rostered on-call. An RN is based in the hospital area on all shifts with four caregivers on the morning and afternoon shifts. One caregiver is on the night shift. In the rest home area, there is an RN on the morning shift and three caregivers. On the afternoon shift there is a senior caregiver and two other caregivers. On the night shift one caregiver is on.  The household staff are also responsible for making the resident’s beds so that the caregivers can concentrate on resident cares. 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 is provided, with staff replaced in any unplanned absence. The FM reported there are 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 first aid certificates are identified on the rosters. The two senior managers are experienced RNs. The CNL is new to the position with the majority of RNs plus the CNL experienced in aged care and have been employed for many 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. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were electronic current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.  Electronic records are stored in a secure portal. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents are admitted to St Johns Hill Healthcare (St Johns) when they have been assessed by the local Needs Assessment and Service Coordination (NASC) Service, as requiring the level of services that St Johns provides. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM) and the clinical nurse leader (CNL). They are also provided with written information about the service and the admission process.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments, and signed admission agreements in accordance with contractual requirements. |
| 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 co-ordinated manner, with an escort as appropriate. The service uses the WDHB transfer form to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident, and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. |
| 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 is current and identifies 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 member 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 include 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 review was consistently recorded on the electronic medicine chart.  There were three residents who self-administer creams or inhalers 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/CNL and FM and recorded on an accident/incident form. The resident and/or the designated representative are advised. In April 2021 there was several medication errors. Evidence was sighted of a comprehensive analysis of any medication errors and corrective actions implanted. Compliance with this process was verified.  Standing orders are not used at St Johns. |
| 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 | 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 in February 2021. Several recommendations made at that time (eg, increasing the amount of meat, vegetables, colour, and fibre served at each meal), have been implemented.  An up-to-date food control plan is in place. A verification audit of the plan by the Whanganui District Council was undertaken 27 July 2020 and verified the plan for 18 months. The plan is due to expire 27 January 2022.  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, is available.  Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. However, documentation in the food service questionnaire does make mention of residents feeling they did not have much input into the menu. St Johns has now put a book in the dining room where residents can write in suggestions of food they would like added to the menu. Residents now have a choice of food options available at the tea meal.  Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed. |
| 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 | If a referral is received, but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CNL. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Within 24 hours of admission to St Johns residents are assessed using a range nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening, and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission, residents assessed as requiring long term care, are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.  In all files reviewed initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident’s condition changes, for long term residents. Interviews, documentation, and observation verified that the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing needs.   All residents’ files reviewed, have current interRAI assessments completed. InterRAI assessments are used to inform the care plan. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed of residents at St Johns, reflected the support needs of those residents, and the outcomes of the integrated assessment process plus other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed.  Care plans evidenced service integration with progress notes, activities note, medical and allied health professionals’ notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| 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 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. 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 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 | The activities programme is provided by a trained diversional therapist and two activity coordinators, seven days a week. The programme in the rest home is offered five days a week, whilst in the hospital it is seven days a week. Residents from the rest home can join in the hospital programme over the weekend if they choose.  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 care plan review every six months.  The planned monthly activities programmes, for each of the two service areas 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 exercises, crosswords, discussion over the teacups, painting bird houses, visiting entertainers, quiz sessions and daily news updates. The activities programme is discussed at the bi-monthly residents’ meetings and minutes indicated residents’ input is sought and responded to (eg, a request for barbecues and cooked breakfasts).  Family satisfaction surveys in January 2021 demonstrated some dissatisfaction regarding staff not supporting residents to be involved in activities. A corrective action plan was put in place to address this and included staff reminding residents each day what activities are on, more one to one activity and a ‘happy hour’. It was acknowledged some residents do not want to attend. A re-audit in June 2021, found no areas requiring improvement. |
| 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 or CNL.  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 or CNL. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short-term care plans are consistently reviewed for infections, pain, weight loss and falls. Progress is evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP/RN/CNL sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to older persons’ mental health services. Referrals are followed up on a regular basis by the RN/CNL or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| 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 | Policies and procedures specify labelling requirements in line with legislation. Documented processes for the management of waste and hazardous substances are in place. Incidents are reported in a timely manner. Safety data sheets were sighted and are accessible for staff. The risk/hazard register was current.  Protective clothing and equipment were sighted that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound understanding of processes relating to the management of waste and hazardous substances. |
| 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 building warrant of fitness is displayed at the front entrance. There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for purpose.  Residents and families confirmed they can move freely around the facility and that the accommodation meets their or their relative’s needs. Passageways are wide and there is room for residents to pass comfortably in all areas.  There is a proactive and reactive maintenance programme that is comprehensive. The buildings, plant and equipment are maintained to a high standard. Maintenance is undertaken by a maintenance person and the owner/director who demonstrated good knowledge. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current. Hot water temperatures at resident outlets are maintained within the recommended range.  There are external areas available that are appropriate to the resident groups and setting including a large external courtyard with seating and shade available for residents to frequent. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside.  Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it. |
| 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 is a mix of rooms with individual and shared full ensuites. There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Bathrooms have appropriately secured and approved handrails provided in the toilet and shower areas and other equipment and accessories are available to promote independence. Separate bathrooms for staff and visitors are available. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All bedrooms provide single accommodation apart from two that are doubles and used for couples only. A portable screen is available should privacy be required. Bedrooms are spacious and allows for residents and staff to safely move around. Equipment was sighted in the rooms with sufficient space for both the equipment and at least two staff and the resident. The residents’ rooms are personalised with their own furnishings, photos and other personal possessions. Residents and families are encouraged to make the room their own. Residents and families commented that the rooms meet their needs. |
| 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 | There are numerous areas for residents to frequent. Good access is provided to the lounges and the dining room areas with residents observed moving freely. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas. |
| 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 | Cleaning and laundry policies and procedures are documented and guide services. The facility is cleaned to a high standard. There are processes in place for the collection, transportation and delivery of linen and residents’ personal clothing.  The effectiveness of the cleaning and laundry services is audited via the internal audit programme and visits from the chemical company representative. Reports from the chemical company representative and completed audits for laundry and cleaning were reviewed. Two cleaners and a laundry person described the management of cleaning and laundry processes including the use of personal protective equipment.  There are safe and secure storage areas and staff have appropriate and adequate access to these areas, as required. Chemicals were labelled and stored safely within these areas, with a closed system in place. Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility.  Residents and families stated they were satisfied with the cleaning and laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | A letter from the New Zealand Fire Service dated 24 March 2004 approving the fire evacuation scheme was sighted. The last drill was undertaken on the 4 February 2021. Emergency and security management education is provided at orientation and at the in-service education programme.  Documented systems are in place for essential, emergency and security services. Policy and procedures document service provider/contractor identification requirements along with policy/procedures for visitor identification.  Information in relation to emergency and security situations is readily available/displayed for staff and residents. Emergency equipment is accessible, current and stored appropriately.  The service has a call bell system in place that is used by the residents, families and staff members to summon assistance. All residents have access to a call bell. Call bells are checked monthly by the owner/director. Residents confirmed they have a call bell and staff respond to it in a timely manner.  The service has documented processes for essential, emergency and security services. Registered nurses, diversional therapists and personnel who drive the van with residents in it are required to complete first aid training. There is at least one designated staff member on each shift with appropriate first aid training. Staff records sampled evidenced current training regarding fire, emergency, and security education.  Information in relation to emergency and security situations is displayed and available for staff and residents with evidence of emergency lighting, torches, gas and BBQ for cooking and extra food supplies. A diesel generator provides at least eight hours of emergency power. Emergency water is maintained in containers and meets the recommended amount for residents and staff for the region. External doors are locked at around 5pm with the main doors locked at around 6.30pm. A call bell is available for visitors to ring after the doors are locked. Sensor lights are situated externally around the facility and CTV cameras are situated in the front entrance and in the two main lounges. A notice at the front entrance advises visitors of this. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | The facility is heated by water filled radiators in both the communal areas and in all bedrooms.  Procedures are in place to ensure the service is responsive to residents’ feedback regarding heating and ventilation in the facility. Residents and families confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.  People who wish to smoke, do so in a covered gazebo situated in an area outside. |
| 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 | St Johns provides a managed environment that minimises the risk of infection to residents, staff, and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed by an external advisory company with input from the FM. The infection control programme and manual are reviewed annually.  The RN with input from the FM is the designated infection control coordinator (ICC), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the FM, and tabled at the quality/RN and staff meetings. Infection control statistics are entered into an external advisory companies electronic database and benchmarked with other aged care facilities in New Zealand. The organisation’s general manager is informed of any IPC concern.  Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| 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 ICC and FM has appropriate skills, knowledge, and qualifications for the role. The ICC has undertaken post graduate training in infection prevention and control (IPC) and recent IPC online training. Well-established local networks with the infection control team at the WDHB and from the local public health unit are available. The coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The FM confirmed the availability of resources to support the programme and any outbreak of an infection.  All residents and staff who have consented to being vaccinated against Covid-19 have had their vaccinations. All staff over 65 years who have consented to having the influenza vaccination have been vaccinated. Those under 65 years are having their vaccinations within the next fortnight. A Covid-19 management plan was sighted, that details appropriate actions required at each alert level. The plan will be reviewed based on Ministry of Health guidelines. While at level one, all persons entering St Johns have their temperatures taken. |
| 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 IPC policies are provided by an external advisory company and reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.  Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation, and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, external specialists, or the ICC. Content of the training was documented and evaluated to ensure it was relevant, current, and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was an influenza outbreak in June 2020.  Training has been provided by the ICC on donning and doffing PPE. All care staff working at St Johns must be assessed as competent before managing catheters. This has been verified by St Johns as a factor in minimising the incidence of urinary tract infections.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather. |
| 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 | 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 skin infections. 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 ICC 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 in the organisation’s electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked NZ wide with the other aged care providers.  A good supply of personal protective equipment is available. St Johns has processes in place to manage the risks imposed by Covid-19. |
| Standard 2.1.1: Restraint minimisation  Services 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 who demonstrated a sound understanding of the organisation’s policies, procedures and practice and their role and responsibilities.  A continuous improvement rating has been awarded relating to the facility maintaining a restraint free environment and 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.

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| 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 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | When analysing the quality data from February 2021 to April 2021, the quality team noted there had been an increase in the incidents of pressure injuries in both the rest home and hospital. There were ten stage one or two pressure injuries at St Johns over this time. Several factors were identified as relevant to their development. These included residents refusing to be turned at night, residents wearing tight fitting shoes that caused pressure on toes, and the limited knowledge of staff regarding factors required to minimise pressure injury risk.  The initiative involved utilising the pressure injury coordinator at the WDHB, who provided education and support. In-service education sessions were held and the staff were introduced to the use of position wedges. These wedges were purchased, as their use evidenced that pressure from areas could be removed or altered without having to “turn” the resident. The use of some draw sheets was stopped as these were found to cause friction. All staff were trained and had a competency assessment done on reducing friction when transferring using transferring devices. Training was provided on how the electric hospital beds could be used to alter a resident’s pressure. Education was provided by the dietitian to enable all staff improved knowledge of the value of high protein diets for residents at risk or with pressure injuries. Newly employed caregivers, once they have completed their orientation, commence the level three Health and Wellness Certificate that includes a unit on preventing pressure injuries. An audit of footwear was undertaken, and new shoes requested when the shoes were a predisposing factor. As a result of this initiative, all pressure areas were healed. There has been one recurrence in June, and the facility is monitoring this closely. | The implementation of an initiative aimed at reducing the incidence of pressure injuries at St Johns, has resulted in a reduction in pressure injuries. |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | Continuous improvement is a strength and focus of the service and this was evident throughout the activities and functions relating to residents, staff, management and governance. 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. 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 pressure injuries and maintaining a restraint free environment. 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. | Opportunities for improvement continue to be pursued by residents, families, staff, and managers alike and evaluation of all aspects of residents’ well-being occurs to ensure quality safe care. |
| Criterion 2.1.1.4  The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | CI | St Johns Hill Healthcare has maintained a restraint free environment since 2014. The journey towards being restraint free has been driven by the FM and staff. Monthly analysis of incidents showed residents using restraint were at a greater risk and as a result an investigated as to why restraints were being used was completed. Interventions were implemented so that restraints were not required. Equipment such as sensor mats and low low beds are used. Bedrails have been removed off existing hospital beds and all beds purchased do not have rails attached. Staff have a firm view that they do not want any sort of restraint in the facility and stated how proud they are to maintaining the service being restraint free. Ongoing training is provided to staff and RNs, caregivers and activities staff have been enrolled to complete the ‘walking in my shoes’ programme. Residents and their families on admission are advised by the FM about the adverse effects of using restraints and the risks around this. Families feedback has been very positive concerning the no restraint and staff confirmed they are very proud that they have implemented strategies, such as, close monitoring and observation of high-risk residents. | St Johns Hill remains a restraint free environment as a result of continuing ongoing training, close monitoring and observations of high-risk residents. All staff have embraced this philosophy and families who ask for their relative to be restrained are advised and educated about the risks. As a result, restraint has not been used since 2014. |

End of the report.