

Little Sisters of The Poor Aged Care New Zealand Limited - St Joseph's

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

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| Legal entity: | Little Sisters of The Poor Aged Care New Zealand Limited |
| Premises audited: | St Joseph's Home & Hospital |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 13 May 2019 End date: 14 May 2019 |
| Proposed changes to current services (if any): | None |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 30 |



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 |

| Indicator | Description | Definition |
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| Yellow | 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 |
| Red | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

General overview of the audit

St Joseph's Home and Hospital provides care for up to 31 residents requiring hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 30 residents. The service is overseen by a manager, who is a Mother Superior and is experienced for the role. She is supported by a nurse manager and assistant manager.

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

This audit has identified that twelve improvements are required in relation to the complaints register, collating and discussing data with staff, corrective action plans, new staff orientation, staff education, timeframes, implementation of care, aspects of medication management, hot water monitoring, the call bells, restraint assessments, and review of the restraint programme.

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. | | Some standards applicable to this service partially attained and of low risk. |
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Policies are implemented to support residents' rights. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). The cultural and spiritual needs of residents are being met. Families are kept informed of any changes to the status of the resident. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Residents and families are made aware of the complaints process.

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. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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The quality and risk management programme includes a service philosophy and measurable goals that are regularly reviewed. Quality activities are conducted. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated.

Input from residents and families is regularly sought. An education and training programme is established. Appropriate employment processes are adhered to and employees have a staff appraisal completed on an annual basis.

A roster provides appropriate coverage for the delivery of care and support.

Continuum of service delivery

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| <p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p> | | <p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
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The registered nurse is responsible for the provision of care and documentation at every stage of service delivery. Sufficient information is gained through the initial support plans, specific assessments, discharge summaries, and the care plans to guide staff in the safe delivery of care to residents. The care plans are resident, and goal orientated. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a review by the general practitioner at least every three months.

The activities team implement a varied activity programme to meet the individual needs, preferences and abilities of the residents. The programme encourages the maintenance of community links. There are regular entertainers, outings, and celebrations.

Staff who administer medication have an annual competency assessment. Medication charts are reviewed three-monthly by the general practitioner.

Residents' food preferences and dietary requirements are identified at admission and accommodated. All meals and baking are cooked on site. This includes consideration of any particular dietary preferences or needs. There is a four-week rotational menu that is reviewed by a dietitian.

Safe and appropriate environment

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| <p>Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.</p> | | <p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
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Appropriate information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. There is a first aider on duty at all times.

The building holds a current building warrant of fitness. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. All resident rooms have ensuites. There is sufficient space to allow for the freedom of movement of residents using mobility aids. The internal areas are well ventilated and heated. External areas are safe and well maintained with sufficient shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Emergency management systems are being implemented.

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. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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St Joseph's has restraint minimisation and safe practice policies and procedures in place. The nurse manager is the designated restraint coordinator. On the day of audit, there were six residents using a restraint and six residents using an enabler.

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. |
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Infection control management-systems are in place to minimise the risk of infection to residents, staff and visitors. A designated infection control nurse has completed regular infection control training in relation to her role. The type of surveillance undertaken is appropriate to the size and complexity of the service. Standardised definitions are used for the identification and classification of infection events.

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) |
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| Standards | 0 | 40 | 0 | 6 | 4 | 0 | 0 |
| Criteria | 0 | 89 | 0 | 8 | 4 | 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) |
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| Standards | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 0 | 0 | 0 | 0 |

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>The Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is being implemented. Discussions with management and staff (five caregivers, two registered nurses, two activities coordinators, one cook, one maintenance, one laundry, one human resources, the nurse manager and mother superior (manager)) confirmed their familiarity with the Code. Interviews with six residents (one rest home and five hospital) and four families (all hospital) confirmed the services being provided are in line with the Code.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p> | FA | <p>The service has in place a policy for informed consent and resuscitation. Completed resuscitation forms were evident in all six resident files reviewed. There was evidence of general practitioner (GP) completed and signed clinically not indicated resuscitation status. General consent forms were evident on all files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Signed admission agreements, enduring power of attorney and activation documentation were evident in resident files sampled.</p> |

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| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | <p>FA</p> | <p>A policy describes access to advocacy services. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with residents and families identified that they are aware of advocacy and how to access an advocate.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | <p>FA</p> | <p>Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | <p>PA Low</p> | <p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available in the foyer. A suggestion box is located in a prominent position at reception. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. They confirmed that any issues are addressed, and they feel comfortable to bring up any concerns. There was no evidence to suggest that complaints received were linked to the quality and risk management system (link 1.2.3.6 and 1.2.3.8).</p> <p>Verbal and written complaints are recorded in a complaint register. There were three complaints logged in the register for 2018 and two for 2019 (year to date). All five complaints reflected evidence on the register of being resolved. Missing was evidence that each complaint had followed policy and HDC guidelines around acknowledgment of the complaint, evidence of an investigation and follow-up with the complainant including informing them of the role of advocacy services.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | <p>FA</p> | <p>There are posters of the Code on display and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the information pack is reviewed in detail with the resident and the family/whānau. The information pack includes a copy of the Code.</p> |

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| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | <p>FA</p> | <p>The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting residents' privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs in regard to maintaining independence, privacy, dignity and respect were being met.</p> <p>A policy describes spiritual care. Mass is conducted daily in the chapel and sisters of the order are available at all times. All residents and families interviewed indicated that resident's spiritual needs are being met when required.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | <p>FA</p> | <p>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. Cultural needs were addressed in care plans sampled. There were no residents who identified as Māori at the time of the audit. Cultural and spiritual practice is supported, and identified needs are incorporated into the care planning process and reviewed as demonstrated in resident files sampled. Discussions with staff confirmed that they are aware of the need to respond to cultural differences. A whānau room provides space for family/whānau to meet. One resident and family member interviewed recalled using the whānau room with all their family, where a meal was served for everyone.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | <p>FA</p> | <p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment, including residents' cultural beliefs and values, is used to develop a care plan that the resident (if appropriate) and/or their family/whānau are asked to consult on.</p> |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | <p>FA</p> | <p>The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect policy covers harassment and exploitation. All residents interviewed reported that staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The employee agreement includes standards of conduct.</p> |

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| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | <p>FA</p> | <p>The service has policies to guide practice that aligns with the health and disability services standards for residents with aged care needs. Residents interviewed spoke very positively about the care and support provided.</p> <p>Evidence-based practice is evident, promoting and encouraging good practice. A house general practitioner (GP) visits the facility once per week. The service receives support from the local district health board (DHB). Physiotherapy services are available twelve hours per week and lead the residents in group exercise classes three times a week. A podiatrist visits every six weeks and a hairdresser is on site once a week.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>FA</p> | <p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Fifteen incident/accident forms reviewed identified that family notification is consistently being documented. Families interviewed confirmed that they are notified of any changes in their family member's health status.</p> <p>Interpreter services are available if required. Staff and families are used in the first instance.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>St Joseph's is owned and operated by the Little Sisters of the Poor. The service provides rest home and hospital level (geriatric and medical) care for up to 31 residents. On the day of the audit, there were 30 residents (2 rest home level and 27 hospital level). Twenty-six were under the age-related residential care (ARRC) contract and one (hospital level) was under a mental health contract.</p> <p>All rooms are dual-purpose and can swing to either rest home or hospital level of care. The manager is a sister of the order. She is new to her role in managing an aged care service but has many years of experience working in aged care facilities in New Zealand and overseas. The nurse manager/registered nurse (RN) is also new to the role of nurse manager. She was employed in August 2018 and has worked in the aged care environment for the past four years. Two of those years have been as a charge nurse.</p> <p>The organisation has a philosophy of care, which includes a mission statement, core values, and objectives. St Joseph's Home and Hospital has a 2018-2019 business/strategic plan with annual goals that are regularly reviewed. The managers have each completed a minimum of eight hours of professional development over the past 12 months.</p> |

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| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | <p>FA</p> | <p>In the absence of the manager, the assistant manager who is a member of the religious congregation is in charge, with support from the nurse manager, registered nurses and care staff. The nurse manager is supported by four permanent nursing staff in her absence.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | <p>PA Low</p> | <p>A quality and risk management programme is established but has not been fully implemented since there was changes to the management team (there have been three different nurse managers over the past 18 months). The monthly collating and analysis of quality and risk data includes monitoring accidents and incidents and infection rates although communicating results to staff is lacking. Internal audits regularly monitor compliance but where improvements are identified, corrective action plans are missing. Annual resident satisfaction surveys are completed but there is a lack of evidence to reflect the collation and trending of results. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed.</p> <p>Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. The service's policies are reviewed at least every two years with the last review taking place in March 2019. Staff have access to policies and procedures. A system of document control is in place with evidence of regular reviews.</p> <p>There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The health and safety officer (human resources officer) has been in the role for nine months and has completed stage two health and safety training. The health and safety committee consists of the manager (mother superior), one RN and two caregivers, maintenance, laundry, kitchen and an assistant to the manager. Meeting minutes are taken. Maintenance orientates new contractors to the health and safety programme. Staff are trained in health and safety during their orientation (link 1.2.7.4). Hazard registers are monitored monthly. Examples were provided of hazards identified and actions taken to minimise the risk of injury (eg, covers for boiling water on bain maries, temporary measures taken while fencing was being repaired). Staff receive manual handling training by a physiotherapist.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward</p> | <p>FA</p> | <p>There is an accidents and incidents reporting policy. A registered nurse conducts a clinical follow-up of each adverse event. The nurse manager investigates all accidents and near misses and analyses results (link 1.2.3.6). Fifteen incident forms reviewed for 2019 demonstrated that an investigation occurred following incidents and that family were informed. This included falls, skin</p> |

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| <p>events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | | <p>tears, and wandering. Missing was consistent evidence clinical follow-up has been undertaken if there was a suspected injury to the head (link 1.3.6.1).</p> <p>Discussion with the nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. This has not been required since the previous audit.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>PA Moderate</p> | <p>There are human resource management policies in place. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates for health professionals is maintained. Seven staff files were reviewed (one nurse manager, two staff registered nurses, one cook and three caregivers). The service has an orientation programme in place that provides new staff with relevant information for safe work practice, but staff are not returning their paperwork to evidence the orientation programme is completed.</p> <p>The in-service education programme for 2018 and 2019 has not been fully implemented. The registered nurses attend external training including sessions provided by the local DHB. All seven RNs have completed their interRAI training. Annual staff appraisals were evident in all staff files reviewed.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <p>Policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The nurse manager is available five days a week (Monday – Friday).</p> <p>There are 30 residents (2 rest home level and 27 hospital level). There is a minimum of one staff registered nurse on at any one time. Three long shifts and two short shift caregivers are scheduled for the AM shift, two long shifts and two short shifts for the PM shift and one for the night shift. Agency staff are used when required to fill vacancies.</p> <p>Interviews with residents and family members identified that call bells are not being answered in a timely manner (link 1.4.7.5). Caregivers interviewed confirmed that they are doing hoist transfers by themselves due to other caregivers being too busy to help them (link 1.3.6.1).</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely</p> | <p>FA</p> | <p>Resident files are appropriate to the service type. Residents entering the service have relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other</p> |

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| <p>identifiable, accurately recorded, current, confidential, and accessible when required.</p> | | <p>residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant caregiver or registered nurse, including their designation.</p> |
| <p>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.</p> | <p>FA</p> | <p>The service has comprehensive policies and procedures in place to safely guide service provision and entry to service. Referring agencies establish the appropriate level of care required prior to the admission of the resident. The service provided residents and family with a well-developed information pack outlining entry to the service, the admission process and the services provided. Residents and relatives interviewed stated they were well informed upon admission and had the opportunity to discuss the admission agreement with the manager. The admission agreements reviewed meet the requirements of the aged residential care contract (ARCC). Exclusions from the service are included in the admission agreement. All six admission agreements viewed were signed and dated.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | <p>FA</p> | <p>The service has comprehensive policies in place to address death, discharge, transfer, documentation and follow-up. Residents who require admission to hospital are managed appropriately and relevant information is communicated to the DHB. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made. A record of transfer documentation is kept on the resident's file. Evidence of transfer documentation was sighted on two of the files sampled.</p> |
| <p>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.</p> | <p>PA Low</p> | <p>There are comprehensive policies and procedures in place for all aspects of medication management. There were no residents self-administering on the day of audit. There is one medication room on site with secured keypad access. All eye drops were dated on opening. The fridge storing medication in the treatment rooms, did not have daily temperature checks documented. There was a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The facility uses a blister pack medication management system for the packaging of all tablets.</p> <p>Registered nurses administer medications. Medication competencies for the RN's were up to date, but annual medication in-service training was not evidenced (link 1.2.7.5). The facility is currently using an electronic medication system. GPs prescribe medication electronically. Prescribed medication administered is signed electronically as observed on day of audit.</p> |

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| | | Twelve medication charts were reviewed. All charts had photo identification and allergy status documented. All medication sheets evidenced three monthly reviews by the GP. Effectiveness of PRN medications administered were documented in the electronic prescriptions. Controlled drugs and registers align with guidelines. |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | FA | <p>There is a well-equipped kitchen and all meals are cooked on site. The service employs one chef and one kitchenhand Monday to Friday and one cook and one kitchenhand at the weekend. The kitchen staff have all completed food safety training. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. The weekday chef oversees the procurement of the food and management of the kitchen. Kitchen fridge, food and freezer temperatures were monitored and recorded weekly. These were all within safe limits. Menu boards in the dining room were updated daily by the kitchen staff. Meals are served from bain maries in the two dining rooms. Special equipment such as lipped plates is available. On the day of audit, meals were hot and well presented. The Sisters of the Order and volunteers assist with the table set up and feeding of the residents during the mealtimes.</p> <p>The residents have a nutritional profile developed on admission that identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen. The kitchen is able to meet the needs of residents who require special diets. Special diets and likes and dislikes were noted in a kitchen folder. Residents were offered choices for evening meals and that was accommodated by the kitchen service.</p> <p>An external dietitian has audited and approved the menus. The service has a current food control plan in place. Residents and families interviewed were very happy with the meals provided.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p> | FA | <p>The service records the reason for declining service entry to potential residents should this occur, and communicates this decision to potential residents/family and the referring agency. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents declined would be referred back to the referring agency for appropriate placement and advice.</p> |
| <p>Standard 1.3.4: Assessment</p> | FA | <p>The level of care of all residents is established by a need's assessment prior to admission. The registered nurse completes an initial assessment on admission that is utilised to develop the initial</p> |

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| <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | | <p>care plan. An interRAI and other relevant assessments are undertaken to establish resident needs (link 1.3.3.3). Ongoing assessments are done in consultation with the multidisciplinary team and significant others. Additional assessments for management of behaviour and wound care were appropriately completed according to needs identified. Initial assessments were in place in all six files reviewed.</p> |
| <p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | <p>FA</p> | <p>The resident care plans reviewed evidenced multidisciplinary involvement in the care of the resident. Overall care plans were resident centred and documented support needs to achieve the resident/relative goals (link 1.3.6.1). Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan if an ongoing problem. Residents and family interviewed stated they are involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, geriatrician, gerontology nurse practitioner and hospice nurse.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>PA Moderate</p> | <p>Registered nurses and caregivers follow the care plan and report progress against the care plan at each shift handover. Overall care plans reviewed included documentation that meets the needs of the residents and care plans had been updated as residents' needs changed. When a resident's condition alters, the RN initiates a review and if required, GP consultation. RNs interviewed confirmed that changes in care are documented on progress notes and are communicated at handover. Family members interviewed confirmed they are notified of any changes in their relative's health status. Family and residents stated care delivery and support by staff is consistent with their expectations.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. Adequate dressing supplies were sighted in the treatment room.</p> <p>Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing monitoring and evaluation forms were in place. Wound management plans were in place for one resident that had two wounds (skin tear and abrasion). Both had appropriate care documented and provided. Access to specialist advice and support is available as needed through Auckland District Health Board.</p> <p>Monitoring forms are in use as applicable for weight, observations, wounds and vital signs. Behaviour charts were in use for any residents that exhibit challenging behaviours.</p> |

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| | | <p>Acute care plans document appropriate interventions to manage short-term changes in health. Nephrostomy catheter changing documentation was incomplete on one resident that had a nephrostomy tube in place. Neurological observations had not been completed for two residents with unwitnessed falls as per policy.</p> <p>Hoist transfers are being done occasionally by one caregiver only.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>The service employs one activities coordinator who works 20 hours (Monday through to Friday). A Sister of the Order assists with the programme. A physiotherapist conducts the morning group exercise programme three times a week. There are numerous volunteers that support the activities programme on a daily basis to assist with reading, manicures and pamper sessions. On the day of the audit residents were observed being involved in the morning exercise programme and playing housie in the hall.</p> <p>The monthly activity programme comprises of a music hour, hand massages, spiritual sharing and reading. There are weekly scenic drive outings and movie sessions on a Saturday afternoon in the hall. Special events such as Mother's Day, birthdays and Easter are celebrated. On Thursdays the activity coordinator and volunteers assist the residents to bake scones and enjoy a morning tea. The last Sunday of every month is dedicated to welcoming new residents to the facility. A weekly newsletter is printed and emailed to all residents and family, this includes the weekly activities programme and facility related news.</p> <p>All long-term resident files sampled evidenced an activity assessment completed on admission, and an individualised activity plan based on the assessment. The activity plan is evaluated at least six-monthly when the long-term care plan is evaluated. Residents that displayed challenging behaviour had individual 24-hour programmes in place to guide the staff. Residents and families interviewed commented positively on the activity programme.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Care plans have been reviewed at various times depending on health status. There is documented evidence that care plan evaluations are completed, however these have not always been completed following the six monthly interRAI reassessment (link 1.3.3.3). The GP reviews the residents at least three monthly or earlier if required. The multidisciplinary review team includes the nurse manager, RN, caregivers and the resident/relative and any other allied health professional involved in the care of the resident. Short-term care plans for short-term needs were evaluated and signed off as resolved or were added to the long-term care plan as an ongoing problem. Activities plans were in place for each resident and these are evaluated at the same time as the care plans. Residents and family members interviewed confirmed they are informed of any changes to the care</p> |

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| | | plan. |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | FA | <p>The service facilitates access to medical and non-medical services. Referral documentation is maintained on resident files. In the files sampled there was evidence of referrals to mental health services for older people and the podiatrist. The nurse manager initiates referrals to nurse specialists and allied health services, all other specialist referrals are made by the GP.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | FA | <p>There are clear policies in place to guide staff in chemical safety and waste management. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. Chemicals sighted were clearly labelled with manufacturer's labels and stored safely throughout the facility. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. A hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | PA Low | <p>The building holds a current warrant of fitness that expires on 8 April 2020.</p> <p>There is a maintenance person employed to address reactive and preventative maintenance. All medical and electrical equipment had been tested and tagged. Chair scales were available and have been calibrated and tagged. Equipment that is not in use have designated storage areas that are located in the closed cupboards for easy access to staff. There was a planned maintenance programme in place. Hot water temperatures in resident areas have not been monitored regularly. Water temperature check last noted was between 43-45 degrees Celsius.</p> <p>All communal areas, hallways and resident rooms are carpeted. All ensuites have nonslip vinyl flooring. Utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Hallways are very wide and have safety rails and promote safe mobility while using mobility aids. The facility has enough space for residents to mobilise using mobility aids and residents were observed moving around freely. The external areas and gardens were well maintained. Residents have access to safely designated external areas that have seating and shade. Staff stated they had sufficient equipment to safely deliver care to meet resident needs.</p> |

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| | | The service has three vehicles to provide transport to residents and for staff usage. All three vehicles had current vehicle warrant of fitness and registration. |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | FA | All resident rooms have large ensuites. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. There is ample space in all ensuites to accommodate shower chairs and hoists if appropriate. There are communal toilets near lounges. The residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | FA | All resident rooms are spacious to allow care to be provided and for the safe use of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day of audit. Staff interviewed reported that they have more than adequate space to provide care to residents. |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | FA | There are numerous spacious communal areas throughout the facility. Activities as observed on the day of the audit are held in the lounges, chapel and hall. The lounges are large enough so there is no impact on other residents who are not involved in activities. The arrangement of seating and space allows both individual and group activities to occur. There was a designated activity room where residents, volunteers and the activity coordinator bake scones and host the morning tea. There are smaller lounges where residents who prefer quieter activities or visitors may sit. The dining rooms are spacious, and the décor is very attractive and homely. There are small kitchenettes located within the facility for family and visitors to make a cup of tea or coffee. |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in</p> | FA | The service has a comprehensive cleaning and laundry manual to guide staff. Safety data sheets are available. The cleaners' equipment was attended-to at all times or locked away in the laundry. Chemicals bottles on the trolley had manufacturer labels. Contracted staff do cleaning. There are two sluice rooms for the disposal of soiled water or waste. The sluice rooms and the laundry were locked when not in use. |

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| <p>which the service is being provided.</p> | | <p>All laundry is undertaken on site. The laundry is spacious and well organised and divided into a 'dirty and clean' area. The laundry staff member interviewed stated that laundry service is adequately managed with the assistance of volunteers. The laundry staff member could describe appropriate systems for managing infectious laundry. Safety data sheets were in place. All chemicals were stored in a locked cupboard.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | <p>PA Moderate</p> | <p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. Civil defence supplies, adequate food and water, and a gas barbeque for alternative cooking are available. In the event of a power cut, there is emergency lighting in place.</p> <p>Six monthly fire evacuations are held. There is an approved fire evacuation plan. There have been no building changes since the previous audit. There is a first aider on duty at all times. Residents' rooms and communal areas have call bells, but the electronic call bell system is reported as not working effectively due to poor Wi-Fi access in the building.</p> <p>Security policies and procedures are documented and implemented by staff. There is security lighting at night and access to the building is by call bell and intercom.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | <p>FA</p> | <p>There is underfloor heating in all areas. The facility has ample natural light and ventilation. A resident room visited on the day of audit had large external windows that open, allowing plenty of light. St Josephs is a smoke free facility.</p> |
| <p>Standard 3.1: Infection control management</p> <p>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.</p> | <p>FA</p> | <p>St Joseph's has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. A registered nurse is the designated infection control coordinator with support from all staff and management. Infection notifications are linked into the incident reporting system. The monthly infection control statistics were displayed on a noticeboard in the nurse's station. Minutes from the staff meetings did not reflect infection control data being communicated to staff (link 1.2.3.6).</p> <p>Internal audits for infection control are included in the annual audit schedule. Corrective action plans based on audit findings have not been documented or implemented to address the areas</p> |

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| | | requiring improvement (link 1.2.3.8). Education is provided for all new staff on orientation and existing staff, topics included are food safety, infection control principals and PPE. The most recent infection control training took place in 2018. The infection control programme has been reviewed annually. |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | FA | For the size and complexity of the organisation, there are adequate resources to implement the infection control programme. A registered nurse is the designated infection control (IC) coordinator. The IC coordinator and IC team has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction (link 1.2.7.4). Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | The suite of infection control policies and procedures are appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated. |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. The orientation package included specific training around hand hygiene, standard precautions and a hand washing competency is to be completed (link 1.2.7.4). Ongoing formal infection control education for staff had occurred on safe food handling, PPE and infection control principals in 2018. The infection control coordinator had completed online infection control updates. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records and care plans. |

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| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | <p>FA</p> | <p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection (link 1.2.3.6). Short-term care plans have been used for all residents diagnosed with an infection. Surveillance of all infections are entered onto a monthly infection summary. This data was monitored and evaluated monthly and annually. If there is an emergent issue, it is acted-upon in a timely manner. There have been no outbreaks since the previous audit.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were six hospital level residents with restraint and six hospital level residents with an enabler. The nurse manager is the designated restraint coordinator.</p> <p>Two enabler files were reviewed. One of the residents using an enabler was actually using a restraint (link 2.2.2.1). In the second enabler file reviewed, it was documented that enabler use was voluntary with consent provided by the resident. All necessary documentation had been completed in relation to the enabler (eg, assessment, link to the resident's care plan, six monthly reviews).</p> <p>Staff interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Education on RMSP/enablers has been provided.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p> | <p>FA</p> | <p>The nurse manager is the restraint coordinator. The assessment and consent process for restraint use includes the restraint coordinator, registered nurses, resident or representative and medical practitioner.</p> |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in</p> | <p>PA Moderate</p> | <p>A process is established for the completion of assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff, in partnership with the family/whānau. In the four files reviewed, assessments and consents were missing for one resident who was being restrained in a lazy boy chair and for one resident who was being restrained</p> |

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| relation to use of restraint. | | with bedrails, although this was documented as an enabler. |
| Standard 2.2.3: Safe Restraint Use Services use restraint safely | FA | Restraint minimisation policies and procedures identify that restraint is to be put in place only where it is clinically indicated and justified, and approval processes are obtained/met (link 2.2.2.1). Monitoring forms documented regular monitoring of the use of the restraint at the frequency determined by the risk level. The service has a restraint and enablers register. There were two lap belts and six bedrails used as enablers for six residents and one lap belt and six bedrails used as restraints for six residents. One file of a resident using restraint did not have this documented in their care plan (link 1.3.6.1). |
| Standard 2.2.4: Evaluation Services evaluate all episodes of restraint. | FA | The service has documented evaluation of restraint every six months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed every month by the restraint coordinator. Evaluation timeframes are determined by policy and risk levels. Any adverse outcomes resulting from the use of restraint would be reported via the adverse event reporting process. None were identified at the time of the audit. |
| Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint. | PA Low | The service actively reviews restraint policies and procedures two-yearly as part of their document control process but there is no evidence of a review of the restraint minimisation programme, including a review of staff education around restraint minimisation (link 1.2.7.5). |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p> | PA Low | A complaints register is being maintained but does not include necessary details around acknowledgement of the complaint, an investigation (if required) and informing the complainant of the outcome in a formal manner although all complaints were documented as resolved. | The complaints register for 2018 and 2019 (year to date) failed to include all actions taken (eg, acknowledgement of the complaint, investigation of the complaint). All of these complaints were documented as resolved. | <p>Ensure the complaints register includes not only the complaint, but all dates and actions taken.</p> <p>90 days</p> |
| <p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where</p> | PA Low | Quality data is regularly collected with graphs indicating trends in data (eg, falls, infections). Meeting minutes are documented, recording information discussed in various | i) Meeting minutes do not reflect evidence of quality results being communicated to staff (eg, internal audit results, adverse | i) Ensure meeting minutes reflect quality results being |

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| appropriate, consumers. | | staff meetings, but meeting minutes do not include evidence of the quality data that is being collected and collated. Staff interviews confirmed that these meeting minutes are also not available to read if they miss a meeting. Annual resident surveys are completed with the most recent survey taking place in August 2018. The individual comments from residents who suggested improvements were addressed, but there was no evidence that all results had been collated and trended to identify areas for improvements. | events, infections). ii) Meeting minutes are not posted for staff to read if they miss the meeting. iii) Although individual comments were addressed in the last resident survey results, they were not collated and analysed to identify trends and possible areas for improvements. | communicated to staff. ii) Ensure meeting minutes are readily available to staff. iii) Ensure resident satisfaction survey results are collated and analysed to ensure that areas requiring improvements are identified. 90 days |
| Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | The internal audits indicate where improvements are required, but there is no evidence that these improvements have been implemented via a corrective action plan. | Three out of nine internal audits completed over the past year indicated that improvements were required (restraint minimisation, environmental safety, staff survey results) but corrective action plans were not developed to address these areas. | Ensure corrective action plans are developed where areas for improvements are identified. 90 days |
| Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the | PA Low | New staff are provided with an orientation programme. Interviews with staff confirmed that their | i) Six of nine staff files reviewed failed to evidence completion of their orientation programme | i) Ensure evidence is retained of staff |

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| <p>essential components of the service provided.</p> | | <p>orientation programme was sufficient to allow them to work independently. Missing was evidence in staff files that the orientation programme was being completed.</p> | <p>(sample expanded to include two staff employed since the last audit).</p> <p>ii) The orientation competency checklist for caregivers and registered nurses has not been differentiated. Both checklists are the same.</p> | <p>completing an orientation programme.</p> <p>ii) Ensure the orientation programme is specific to the new employee's job role and responsibilities.</p> <p>90 days</p> |
| <p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p> | <p>PA Moderate</p> | <p>Annual education schedules have been developed but have not been fully implemented over the past two years. The nurse manager confirmed her awareness of this gap in staff training and states that plans are in place to begin staff training later in the month. There is also a lack of evidence to indicate that caregivers are provided information on Careerforce training opportunities.</p> | <p>A 2019 education schedule has been documented for the service but has not yet commenced. In-services are scheduled to begin at the end of May 2019. Only five hours of in-service education were provided in 2018 as indicated in the education log book (hazard reporting, infection control, food safety, last days of life, and one attendance record that did not indicate what topics were covered). Caregivers and RNs reported that in-service education has been lacking over the past 18 months and that they would like to have more in-service education. Caregivers interviewed were unaware of any Careerforce training programmes available.</p> | <p>Ensure regular in-service education is provided for staff and that it meets DHB contract requirements. Caregiver staff also need to be made aware of how they can enrol in a Careerforce training programme.</p> <p>90 days</p> |

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| <p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p> | <p>PA Low</p> | <p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medications are received from the pharmacy and stored in the treatment rooms.</p> | <p>The daily temperature checks for the medication fridge in the treatment room were not documented.</p> | <p>Ensure regular medication fridge temperature checks are completed daily and documented at least weekly.</p> <p>60 days</p> |
| <p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p> | <p>PA Low</p> | <p>All files reviewed had an initial assessment and care plan completed within 24 hours of admission. In one of the long-term files reviewed, the interRAI assessment and care plan was not developed within 21 days of admission. In three of the files reviewed, the interRAI assessments and care plan evaluations were not completed six-monthly.</p> | <p>(i) The interRAI assessment and long-term care plan had not been completed within 21-days of admission in one long-term resident file (hospital level of care).</p> <p>(ii) Six-monthly interRAI and care plan evaluation had not been completed in three of the six resident files (hospital level of care).</p> | <p>(i) Ensure the interRAI assessment is completed within 21-days of admission.</p> <p>(ii) Ensure the interRAI assessment and care plan evaluations are completed six-monthly on all long-term residents.</p> <p>90 days</p> |
| <p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p> | <p>PA Moderate</p> | <p>Monitoring occurs for weight, vital signs, pain, continence and two hourly positioning. One resident who had a nephrostomy tube in place had incomplete documentation of dates and times</p> | <p>(i) There was incomplete documented evidence of nephrostomy catheter tube changes for one hospital resident that had a nephrostomy tube in</p> | <p>(i) Ensure nephrostomy catheter tubes are changed as prescribed, and the dates and</p> |

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| | | <p>when nephrostomy catheter tube was changed. Two residents had no neurological observations evidenced post unwitnessed falls.</p> <p>Policy and best practice mandates two persons are required for all hoist transfers. This requirement has been discussed in staff meetings (meeting minutes sighted). Interviews with caregivers (two groups of caregivers; one group of three caregivers on day one and one group of two caregivers on day two of the audit) stated that they may do as many as four or five hoist transfers per week on their own because a second person is not readily available in their area to assist them.</p> <p>One file of a resident documented on the restraint register as using restraint did not have restraint use documented in their care plan.</p> | <p>place.</p> <p>(ii) Neurological observations had not been completed for two residents with unwitnessed falls as per policy.</p> <p>(iii) A sample of caregiver interviews confirmed that they are single-handedly using the hoist to transfer residents approximately three to four times per week.</p> <p>(iv) Residents using restraint or enablers are required to have this documented in their care plan. This was missing in one of the two resident's files sampled where the use of restraint was documented in the restraint register.</p> | <p>times documented.</p> <p>(ii) Ensure neurological observations are completed for unwitnessed falls.</p> <p>(iii) Ensure a minimum of two persons are always present during hoist transfers.</p> <p>(iv) Ensure restraint use is documented in the care plans of all residents using restraint.</p> <p>30 days</p> |
| <p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p> | PA Low | <p>The facility had a planned maintenance programme in place to cover reactive and preventative maintenance of plant and equipment. The hot water temperatures were not regularly monitored and recorded.</p> | <p>Hot water temperatures are not regularly monitored and recorded.</p> | <p>Ensure hot water temperatures are monitored and documented regularly.</p> <p>90 days</p> |

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| <p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p> | <p>PA Moderate</p> | <p>An electronic call system is in place that is linked to staff pagers. This system is not reliable, and a new part has been ordered to remedy this problem.</p> | <p>(i) The call system is not working properly both with the main server and with the staff pagers. This has been identified as an issue related to Wi-Fi access and a new system has been ordered.</p> <p>(ii) Three of four families and two of six residents interviewed stated that call bells were not answered in a timely manner. A call bell report was reviewed for ten rooms over a period of 10 days. Call bell response times exceeded 10 minutes in 29 instances of residents using their call bell.</p> | <p>(i) Ensure an effective call system is in place to allow staff to answer call bells in a timely manner.</p> <p>(ii) Ensure call bells are promptly answered.</p> <p>30 days</p> |
| <p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending</p> | <p>PA Moderate</p> | <p>A restraint assessment process is in place that includes all aspects of the criterion (a) – (h). Three residents' files were reviewed. One resident was using restraint, but restraint processes were not followed. A second resident did not have their restraint linked to their care plan (link 2.2.3.2) and the third resident using restraint was initially assessed as using an enabler (8 July 2015) but the resident file had not been updated to reflect that the bedrails were now a restraint.</p> | <p>(i) One resident was being restrained in a lazy-boy chair with the control for the lazy boy chair placed out of his reach to prevent him from lowering the leg rest and trying to get out of the chair. This resident has not been assessed for restraint use.</p> <p>(ii) One enabler (bedrails) was actually a restraint due to the resident being unable to voluntarily consent to the use of the bedrails. All documentation in the resident's file was around use of an enabler.</p> | <p>(i) Ensure restraint procedures are followed for all residents whose freedom of movement is limited to keep them safe.</p> <p>(ii) Ensure all enablers are voluntary, otherwise should be managed as restraint.</p> |

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| <p>restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies.</p> | | | | 60 days |
| <p>Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education.</p> | PA Low | <p>Restraint policies and procedures are reviewed two-yearly but there is no evidence to suggest that reviews are taking place in relation to trends around restraint use, restraint education and ensuring that staff follow restraint policies and procedures.</p> | <p>There has been no evidence of the review of the restraint minimisation programme to identify trends, adherence to the restraint policies and procedures, and staff education.</p> | <p>Ensure the restraint programme is reviewed regularly. 90 days</p> |

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

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End of the report.