

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

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	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: 14 December 2020 End date: 15 December 2020
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:	31

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Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
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 31 residents. The service is overseen by an experienced manager, (Mother Superior) who is supported by a nurse manager.

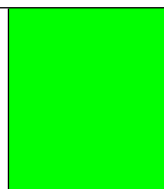
This surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, relatives, management, staff, and a general practitioner.

This service has addressed the 12 previous audit shortfalls around 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.

There are no corrective actions identified at this audit.

Consumer rights

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



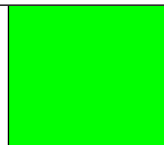
Standards applicable to this service fully attained.

Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents and family are communicated with at regular and frequent intervals and when incidents occur.

A complaints policy is documented, and a complaints register maintained. Complaints were responded to in a timely manner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Standards applicable to this service fully attained.

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

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 nurse manager and registered nurses are 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

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

Standards applicable to this service fully attained.

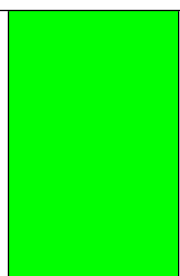
The building holds a current building warrant of fitness. Ongoing maintenance issues are addressed.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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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 no residents using a restraint and two residents using an enabler. The service has worked to significantly reduce the number of residents using restraints or enablers since the last audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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	19	0	0	0	0	0
Criteria	0	44	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available 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 is evidence in meeting minutes to confirm that that complaints received are linked to the quality and risk management system. The previous shortfall identified at the certification audit has been addressed.</p> <p>Verbal and written complaints are recorded in a complaint register. There were two complaints logged in the register for 2020 (year to date). Both complaints reflected evidence on the register that they had been investigated and resolved in a timely manner in line with policy and the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). This included informing the complainant of the role of advocacy services. The previous shortfall identified at the certification audit has been addressed.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>Seven residents interviewed (three rest home and four hospital) and two family members (with family using hospital level of care) 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. Sixteen incident/accident forms reviewed identified that family notification is consistently being</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>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>The nurse manager and staff interviewed, including four HCAs, one registered nurse, one activities coordinator, the cook and maintenance staff confirmed that they encouraged open and transparent communication with residents and family.</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 31 residents (10 rest home level and 21 hospital level). All were under the age-related residential care (ARRC) contract.</p> <p>All rooms are dual-purpose (rest home or hospital level of care). The manager is a Sister of the Catholic Order (Mother Superior). The manager has been in the role for three years. The nurse manager has been a registered nurse in the service for nine years and has been in the role for one year. They have a postgraduate diploma in health science. Two other RNs provide clinical and operational oversight and support. Both are Sisters of the Order and have been a registered nurse in aged care for over 20 years each with past experience in hospital and rest home management in other facilities.</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 2020-2021 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>
<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</p>	<p>FA</p>	<p>A quality and risk management programme is established and fully implemented. The monthly collating and analysis of quality and risk data includes monitoring accidents and incidents and infection rates with results communicated to staff through meetings with minutes recorded. Meeting minutes are posted for staff to read if they miss the meeting. Internal audits regularly monitor compliance and where improvements are identified, corrective action plans are now documented with evidence of resolution of issues. Annual resident satisfaction surveys are completed and there is evidence to reflect the collation and trending of results. The previous shortfalls identified at the certification audit have been addressed.</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>principles.</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 over two years and has completed stage two health and safety training. The health and safety committee consists of the manager (Mother Superior), nurse manager, RN and two caregivers, maintenance, laundry, kitchen staff. Meeting minutes are taken. Maintenance orientates new contractors to the health and safety programme. Staff are trained in health and safety during their orientation. Hazard registers are monitored monthly. Examples were provided of hazards identified and actions taken to minimise the risk of injury. Staff receive manual handling training by a physiotherapist.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</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. Sixteen incident forms were reviewed for 2020 and these demonstrated that an investigation occurred following incidents and that family were informed. This included falls, skin tears, and wandering. There was consistent evidence that clinical follow-up had been undertaken if there was a suspected injury to the head.</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</p>	<p>FA</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. Five staff files were reviewed (one nurse manager, two registered nurses, and two caregivers). The service has an orientation programme in place that provides new staff with relevant information for safe work practice. A review of documentation confirmed that staff had completed the orientation programme. The previous shortfall identified at the certification audit has been addressed.</p> <p>The in-service education programme for 2020 has been fully implemented. The registered nurses attend external training including sessions provided by the local DHB. Eight of the nine RNs have completed their interRAI training. Annual staff appraisals were evident in all staff files reviewed. Staff are also encouraged to complete Careerforce training. The previous shortfall identified at the certification audit has been addressed.</p>

legislation.		
<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>	FA	<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 31 residents (10 rest home level and 21 hospital level). There is a minimum of one staff registered nurse on at any one time. The building is separated into two wings – Jeanne Jugan (15 beds with 4 rest home and 11 hospital residents) and Holy Rosary (16 beds with 6 rest home and 10 hospital residents). Each wing has two corridors. Each corridor in each of the two wings is staffed by one HCA morning and afternoon (ie, four HCAs in the morning and afternoon and one HCA overnight). There is a registered nurse on duty on each shift. There are also two RNs who live on site who are able to come at any time to support the staff (eg, for increases in acuity or to respond to on call requests). Agency staff are used when required to fill vacancies. Staff stated that the two RNs on call respond immediately to any request.</p> <p>Interviews with residents and family members identified that call bells are answered in a timely manner. Caregivers interviewed confirmed that they have sufficient staff on duty to safely complete cares, including transfers.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are 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, has daily temperature checks documented. The previous shortfall identified at the certification audit has been addressed.</p> <p>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 RNs were up to date, as was annual medication in-service training. The facility is using an electronic medication system. GPs prescribe medication electronically. Prescribed medication administered is signed electronically as observed on day of audit.</p> <p>Ten 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> <p>There are no vaccines on site. Ambient temperature of the medication room is recorded.</p>
<p>Standard 1.3.13: Nutrition, Safe Food,</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</p>

<p>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>		<p>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 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</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. There were three residents with a wound (two skin tears and one ulcer). Each wound had an assessment and wound management plan with evaluation of each wound documented. One wound (an ulcer) was being dressed by the district nurse and was noted to be healing. 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> <p>Acute care plans document appropriate interventions to manage short-term changes in health. The previous certification audit identified shortfalls related to the following: changing of nephrostomy catheter tubes; completion of neurological observations for unwitnessed falls; a minimum of two persons present during hoist transfers; and</p>

		<p>documentation of restraint use in the care plans of all residents using restraint. There were no residents with a nephrostomy catheter during this audit. Six of the sixteen incident forms reviewed were for residents who had an unwitnessed fall, and all had neurological observations taken as per policy. Staff stated that there were always enough staff on duty for two staff to use a hoist and this was observed to occur during the audit. The nurse manager and registered nurses have reviewed the need for restraint and use of enablers. Restraint is no longer used, and enabler use has also decreased. Staff were able to describe how any interventions would be recorded in the care plan or on short-term care plans when required. The previous shortfalls identified at the certification audit have been addressed.</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 (Sister of the Order) who works 20 hours (Monday through to Friday). A caregiver also assists with the programme for 20 hours a week. 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, the residents and activity staff were preparing for the Christmas services.</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 a detailed 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 following the six monthly interRAI reassessment. 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.</p> <p>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</p>

		changes to the care plan.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current warrant of fitness that expires on 8 April 2021.</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 been monitored regularly. The previous shortfall identified at the certification audit has been addressed. 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> <p>The service has three vehicles to provide transport to residents and for staff usage. All three vehicles had current vehicle warrants of fitness and registration.</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>	FA	<p>Residents' rooms and communal areas have call bells, but the electronic call bell system is reported as now working effectively due to an improved Wi-Fi access in the building. There is a first aider on duty at all times.</p> <p>The nurse manager has led improvements in answering call bells since the certification audit. Numbers of call bells unanswered for longer than 10 minutes has reduced from between 400-500 monthly to less than 12 monthly. A monthly report is kept and tabled at staff meetings with a trend analysis showing expedient improvements from 2018 to 2019 to 2020.</p> <p>Strategies that have been put in place to address the issue raised have included reminders and prompting at each monthly meeting, checks prior to the start of each shift that pagers are turned on/not muted, all staff members are required to carry a pager and sign for it at the beginning of their shift, and promotion of working as a team. Caregivers stated that they are proud of their achievements in answering bells promptly and stated that it is due to the leadership shown by the nurse manager. Caregivers confirmed that they also read and sign the minutes of portfolio evaluations related to call bells and improvements made on a monthly basis.</p> <p>Families and residents interviewed stated that call bells were answered in a timely manner. The shortfall identified at the certification audit has been met.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<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. Short-term care plans have been used for all residents diagnosed with an infection with incident forms documented when an infection has occurred. 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. There has been training around Covid-19 and implementation of the pandemic plan. There is sufficient PPE on site for at least two weeks should there be an outbreak of Covid-19 or other. There have been no outbreaks of infection since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. The nurse manager has led a review of use of restraint and enablers. There are now no residents using restraint and two rest home level residents with an enabler (bedrail) for one resident who is afraid they may fall out of bed and a lap belt for one resident when using a wheelchair. The nurse manager is the designated restraint coordinator.</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 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment process is documented in the policy and this includes all aspects of the criterion (a) – (h). Restraint is no longer used in the service however the nurse manager and care staff described completing an assessment if that was required in the future, as per the policy. They also described how the assessment would be linked to the care plan with updates to the care plan as required. Staff interviewed described the difference between an enabler and a restraint.</p> <p>All residents were observed on the day of audit to have the control of a lazy boy chair in reach if they used one.</p> <p>The improvement required at the certification around ensuring that restraint procedures are followed for all residents whose freedom of movement is limited to keep them safe ensuring that the use of enablers is a voluntary decision has been met</p>
<p>Standard 2.2.5:</p>	FA	<p>The service actively reviews restraint policies and procedures two-yearly as part of their document control process.</p>

<p>Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>		<p>A comprehensive review of the restraint minimisation programme, including a review of staff education around restraint minimisation, a review of policies and procedures related to restraint minimisation and a review of trends around restraint use has occurred. This has resulted in specific interventions that are relevant to the needs of each resident. Restraint is no longer used in the service. The previous shortfall identified at the certification audit has been addressed.</p>
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.