

St Patricks Limited - St Patricks Home and Hospital

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 Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	St Patricks Limited
Premises audited:	St Patricks Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 31 July 2018 End date: 1 August 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	57

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 Patricks Home and Hospital can provide care for up to 60 residents. On the day of this audit there were 57 residents residing at the facility. This surveillance audit was conducted against the relevant Health and Disability Services Standards and the service contract with the district health board.

The audit process included the review of policies, procedures and resident and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

The previous requirements for improvement from the last provisional audit relating to advanced directives, informed consent relating to resuscitation, care plan documentation including resident and family involvement, signing by registered nurses, and wound care have been closed.

Requirements for improvement from the previous audit relating to informed consent for the use of surveillance cameras, short-term care plan documentation and restraint remain open.

There were additional areas requiring improvement identified at this audit relating to long-term care planning; evaluation; medicines management processes, food safety management and service provider availability. The finding related to service provider availability was identified as high risk.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---	--	---

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service is provided to residents. This information is provided to prospective residents and family members along with information about the facility, prior to entry to the service.

The manager is responsible for the management of complaints. Complaints are documented, investigated and responded to within the required timeframes and an up-to-date register of compliments and complaints is maintained.

Family are informed in a timely manner if any changes occur in the resident's condition. Residents are free to attend monthly resident meetings in either Chinese or non-Chinese speaking languages. Family meetings are also held.

Staff represent a range of nationalities reflective of the resident population, including Pacific Island peoples and Chinese. There are staff able to communicate with residents in their preferred dialect. Interpreters can be accessed externally through the district health board or language line if required.

Residents and family member interviews confirmed that communication is free and frank and that resident rights are upheld. Staff were observed to interact with residents and family members in a manner that was respectful.

Organisational management

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

St Patricks Home and Hospital is governed by three owners/directors. The manager and acting clinical manager are suitably qualified and have been in their roles for just under one year. They are co-owners of the facility, along with a third owner who undertakes facility maintenance. The manager is responsible for the overall management of the facility and is supported by an acting clinical manager, the third owner and registered nurse. The new owners have adopted the company's business, quality risk and management plan developed under previous ownership and implement the organisation's strategy through this.

The facility has an incident and accident management system that records and reports all adverse, unplanned or untoward events, including appropriate statutory and regulatory reporting. Documentation and interviews confirmed that staff communicate with residents and family members about incidents.

There are human resource policies in place and include recruitment, selection and appointment of appropriate staff. Induction includes orientation and buddying with experienced staff. Regular training and education is provided through an in-service education programme. Staff competencies across a range of skills are also assessed routinely.

There is a documented quality and risk management system. Quality and risk performance is monitored, graphed and reported to the owners and to staff at staff meetings. This includes the results of an annual internal audit programme and collated results of incidents and accidents that are monitored by the manager and results inform quality improvements.

Registered nurses are on duty seven days per week and are supported by care staff. Staffing occurs in line with weekly rosters.

Continuum of service delivery

<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>
---	--	---

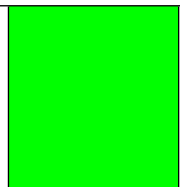
Residents' records sampled provided evidence that residents have been assessed appropriately prior to admission to this facility by the needs assessment service coordinators. InterRAI assessments, risk assessments, care plans and evaluations are completed by the registered nurses. Interviews confirmed residents and their families are informed and involved in care planning and the evaluation of care. Handovers, progress notes, diaries, medical and allied health notes guide continuity of care.

The activities programme provides residents, including younger persons with disabilities, with a variety of individual and group activities. Community outings are arranged, entertainers and community groups are invited to participate in the programme.

Staff responsible for medication management have attended annual education and completed annual medication competencies. There were no residents self-administering medicines on the days of audit.

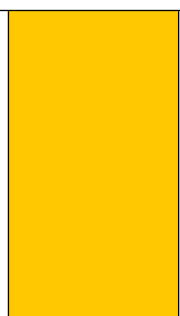
All food is cooked on site in a commercial kitchen. The food service is managed by the cook. Nutritional needs of residents are assessed on admission and additional requirements/modified needs are met. The menu is reviewed by a dietitian. Residents interviewed confirmed satisfaction with the food service.

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.
--	---	--

There is a current building warrant of fitness.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
---	---	--

St Patricks Home and Hospital implement policies and procedures to support restraint minimisation. Restraint minimisation is overseen by the acting clinical manager. There is a restraint register and an enabler register. There were two residents using restraint at time of audit. Although there were no enablers being used at the time of the on-site audit, interviews and/or policy confirmed that enabler use is voluntary when used by residents.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
--	--	---

St Patricks Home and Hospital undertakes infection control surveillance which is appropriate to the size and complexity of this service. Infection surveillance is conducted and collated monthly. This data is analysed, trends identified and reported to staff and management. Results are reported to the staff on a monthly basis.

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	8	0	3	6	1	0
Criteria	0	33	0	3	7	1	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 1.1.10: 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>	<p>PA Moderate</p>	<p>The facility has an informed consent policy and procedure that aligns to Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code), and includes when and how consent should be obtained, and who can provide consent, including competency and advance directives. The informed consent policy and procedure includes guidelines for consent for resuscitation/advance directives and this part of the previous requirement for improvement has been closed out. However, the policy does not include the use of surveillance cameras. This part of the previous requirement for improvement remains open.</p> <p>A review of files demonstrated that advance directives were signed by the competent resident. Where the GP has signed the advance directive as ‘not for resuscitation’, it states that ‘in the doctor’s medical opinion that resuscitation in not advisable’. The previous finding relating to advance directives has been addressed.</p> <p>All resident files identified that informed consent is signed for the following: routine cares and procedures; information to be collected; sharing of information with family; routine procedures to be carried out; and use of a photograph. The informed consent provided by residents and families/EOPA does not include providing consent to the surveillance cameras in the communal and external areas of the facility. The previous finding relating to the service not obtaining consent from residents and/or families/EPOAs for the use of surveillance cameras, remains open.</p> <p>The manager or acting clinical manager (ACM) discusses informed consent processes with residents and their families/EPOA during the admission process. Staff interviews confirmed their understanding of the informed consent</p>

		<p>processes.</p> <p>Residents sign an admission agreement on entry to the service and resident and family interviews confirmed that consent is sought prior to the provision of services and treatment.</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>	FA	<p>The facility has a complaints policy that is in line with right 10 of the Code and details the responsibility of the manager and staff. Staff are aware of their responsibility to ensure residents have an opportunity to lodge a complaint. The manager is responsible for complaints management.</p> <p>Complaints reviewed demonstrate resolution and documentation to support closure. Systems are in place to ensure residents and their family are advised of the complaint process and their rights under the Code.</p> <p>The complaint process is readily accessible and complaints forms are displayed for easy access. Residents and family interviewed confirmed having an understanding and awareness of these processes, and that any issues raised, were addressed. There is a complaints and compliment form that incorporates an outline of the complaints process for residents and family/EPOA. Complaints may be lodged anonymously.</p> <p>Monthly resident meetings minutes confirmed that residents and their families/EOPA are also able to raise any issues they have during these meetings.</p> <p>A complaints and compliments register is in place that details: the date the complaint is received; by whom the complaint was made; a description of the complaint; actions taken and sign off. There have been three complaints logged in 2018 and these indicate that two complaints have been investigated and resolved and one recent complaint is still progress.</p> <p>Currently there is one Health and Disability Commissioner's enquiry (January 2018) and one district health board enquiry (August 2017) that remain open. Documentation reviewed confirmed that the facility has provided evidence as requested and are awaiting the outcome/closure of the investigation.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>Information about the facility and services, in the form of brochures and information leaflets, is provided to prospective residents and their families on enquiry prior to admission. The resident admission agreement, signed by residents or their representative on entry to the service, details information about services provision.</p> <p>There are monthly family and resident meetings. Residents have the option to attend either a meeting for Chinese speaking residents facilitated by a Chinese speaking staff member or an English speaking meeting. Interviews with residents and family confirm that they are able to attend meetings and raise concerns. Meeting minutes demonstrate that residents and family are advised of a range of facility updates and take the opportunity to provide feedback into service delivery, as well as raise any concerns. There is evidence that resident feedback, is acted</p>

<p>communication.</p>		<p>upon with residents updated at subsequent meetings.</p> <p>The facility has an implemented open disclosure policy that defines the key principles of open disclosure and requires that information about an adverse event be communicated to the resident and their support person in a timely, open and honest manner. The residents' files reviewed provided evidence that communication with family members is documented in a residents' communication record. Following adverse events or a change in resident health status, there is evidence of staff contacting and informing the resident's family/enduring power of attorney (EPOA).</p> <p>Staff are familiar with how translating and interpreting services can be accessed externally through the district health board (DHB) or language line if required. However, current staff represent a range of nationalities reflective of the resident population, including Pacific Island peoples and Chinese, and were observed communicating with residents in their preferred dialect.</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>The organisation's vision, values, mission statement and philosophy are displayed on the wall of the reception, at the entrance to the facility and the philosophy is communicated to residents in the facility's information booklet. The facility's scope, mission, philosophy direction, goals and objectives are detailed in the business, quality risk and management plan. The plan includes a risk analysis and quality planning. Goals and objectives are reviewed and reported annually.</p> <p>The current owners took over ownership of the facility in April 2018 and have retained all strategic, quality and operational processes developed and implemented by previous ownership.</p> <p>The manager has overall responsibility for the facility and is supported by an ACM, who is responsible for clinical matters. Both the manager and the ACM are registered nurses (RN) with current annual practising certificates. The facility manager has a masters in nursing and previous experience with the DHB working in rehabilitation services. The ACM has previous clinical manager experience in aged residential care. The auditors were advised that the ACM is to be appointed as the clinical manager. The facility manager and ACM have been in their roles for just under one year. Both the manager and ACM are owners/directors of the facility. A third owner/director provides maintenance services to the facility.</p> <p>The facility can provide care for up to 60 residents. There are 8 beds that are designated at rest home level and the remaining 52 are designated as dual purpose beds. At the audit there were 57 residents in the facility, including 18 residents requiring rest home level of care and 39 residents requiring hospital level care. Of the residents requiring hospital level of care one was identified as a young person with a disability (YPD) under a chronic care long-term contract.</p> <p>Of the 57 current residents, there are 8 rest home level residents and 4 hospital level residents, including the YPD resident, accommodated in 2 external units at basement level of the facility. This includes a block of seven separate units, one of which is a double, providing accommodation for eight residents, six of whom are receiving rest home</p>

		<p>level care and two who are receiving hospital level of care. The other external unit, called the cottage, has 4 rooms with a shared kitchen/lounge room. This cottage provides accommodation for 4 residents, 2 of whom are receiving rest home level care and 2 who are receiving hospital level of care (refer to 1.2.8.1).The facility has a contract for respite care, however, there were no residents under this contract at the time of the audit.</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>	PA Low	<p>The organisation has a business, quality, risk and management plan that provides a framework for quality service to guide practice. St Patricks implements organisational policies and procedures to support service delivery. Policies have been reviewed, by an external consultant with input from the ACM and manager. Policies and procedures are in place to guide staff. New and revised policies are presented to staff at staff meetings.</p> <p>A quality improvement plan with quality objectives are used to guide the quality programme. The facility has policy and procedures to ensure documentation is correctly controlled including: new/issue; alteration/review; and management of obsolete documents.</p> <p>Service delivery is monitored through: complaints; incidents and accidents; and implementation of an internal audit programme. Results are graphed and analysed and discussed at staff meetings, as well as resident meetings. However, the corrective action plans for internal audits do not include timeframes for implementation and/or sign-off is not consistently recorded.</p> <p>There are regular monthly combined staff meetings that include quality, clinical updates, and health and safety. Clinical indicators and quality improvement data is recorded and staff are informed at staff meetings. However, the corrective action plans for meeting minutes do not consistently include identification of the person responsible for implementation of the corrective actions and timeframes and/or sign-off is not consistently recorded.</p> <p>There is a hazard register that identifies health and safety risks, as well as: risks associated with human resource management; legislative compliance; contractual risks; and clinical risk. A health and safety manual is available that includes relevant policies and procedures. Family/resident and staff satisfaction surveys are completed as part of the annual quality programme. Collated results are compared with previous surveys.</p> <p>Interviews with residents confirmed they have opportunity to contribute to quality improvement processes. This includes expressing preferences regarding meals, their care, the use of equipment and their social activities.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or</p>	PA Moderate	<p>Interview with the manager confirmed an understanding of the circumstances/events that require the facility to notify statutory authorities. This includes police attending the facility, unexpected deaths, critical incidents and infectious disease outbreaks. Previous notices are documented and retained on files.</p> <p>Staff training records demonstrated they receive education regarding the incident and accident reporting process. Staff interviews confirmed an understanding of the adverse event reporting process. Staff stated that there is</p>

<p>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>feedback provided in relation to the management and outcomes of adverse events at monthly staff meetings.</p> <p>Reported accident/incidents reviewed demonstrated that not all incidents/accidents are reported on incident forms. Reported incidents/accidents are investigated and closed out and there is evidence that corrective actions were implemented.</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>The organisation has human resource policies and processes in place related to recruitment and staffing ratios. Registered nurses hold current annual practising certificates and these are validated annually. Staff files include employment documentation such as job descriptions and contracts on file. Police checks were completed for some staff, however, these are not evidenced for all staff. There was no evidence of a staff performance appraisal process being completed within the preceding year.</p> <p>Interviews and staff records demonstrate that staff have completed an orientation programme, following recruitment and this includes working alongside an experienced staff member (buddy) until confident and competent. The facility has a competency file for each staff member that demonstrates that staff are required to attain competency in role related tasks, such as medication. Regular staff training is provided, and this includes training at each monthly staff meeting, although not all staff involved in food services have completed food safety training (refer to 1.3.13.1). Records maintained include evidence of attendance at training of at least eight hours a year for each staff member. Four RNs, including the manager, have completed interRAI assessment training.</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>PA High</p>	<p>The staffing rationale guidelines form the foundation for workforce planning. Staffing ratios are based on the numbers of residents by type and the number of care hours to meet resident acuity. Staff interviewed stated that staffing levels are reviewed and allocated according to anticipated workloads, identified resident numbers and appropriate staff skill mix, or as required due to changes in the services provided. However, due to the residents with hospital level care needs residing in external units at basement level of the main building, there is a risk that not all residents receive the oversight and hospital level care they may require in a timely manner. The auditors observed that access to the external units, where 12 residents including 4 hospital level residents were residing on the level below the main facility, required staff to leave the main facility (via a lift or stairs) to the basement level and cross the carport to access the external units. In addition there are no specific staff allocated to work in these areas, with the exception of answering call bells. There was no evidence of a nurses' station in or in close proximity to the external units and no assurance that all residents received the oversight/care required to meet their specific needs.</p> <p>A review of the staff list provided demonstrated that there were 34 permanent staff employed, including</p>

		<p>management, 4 RNs, care staff, activities staff and household staff. In addition to the permanent staff there are 14 staff employed on a casual basis to supplement staffing rosters, including 1 RN.</p> <p>Residents are encouraged to be as independent as possible and to engage in rest home daily activities. Residents and families confirmed that whilst staff appeared to be busy, their needs were met in a timely manner.</p> <p>The manager and ACM are available after hours on call. In the advent of leave for the manager, the ACM will provide cover.</p> <p>A sample of rosters reviewed demonstrated that the manager and ACM were on duty during the day Monday through to Friday inclusive. In addition there was at least one RN on duty each morning, afternoon and night shift seven days per week. There was an overlap where there were two RNs on duty between 8 pm and midnight. In addition to an RN, there were typically 7 health care assistants (HCA) on duty on the morning shift, 4 on the afternoon shift and 2 overnight.</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>	<p>PA Moderate</p>	<p>There are policies and processes describing medication management (including guidelines for the management of warfarin) that align with accepted guidelines, with the exception of respite care medication management. Medicines are delivered in a pre-packed delivery system. The medicines room where medicines are stored in locked medicine trolleys is secure. However, storage of dialysis medicines observed on audit was not in line with safe storage of medicine guidelines. The medication refrigerator temperatures are monitored and recorded weekly.</p> <p>Medication reconciliation is completed. Weekly checks and six-monthly stocktakes are documented. A system is in place for returning expired medicines to the pharmacy. A computer based medication system is used. Review of standing orders in use at time of audit evidenced these were not current.</p> <p>Medication records are reviewed at least three monthly or sooner if required. All medication records have photo identification and known allergies identified. Observation of the lunchtime medication round evidenced compliance with legislation and guidelines. Medicines reviewed included the date, medicine name, dose and time of administration and maximum dosages as required.</p> <p>There were no respite residents on audit days. The respite medication management process was reviewed through discussion with staff and policy documentation. Interview with the ACM, RNs and review of medication management policies and processes confirmed residents admitted for respite care have an assessment completed and the respite medicines are managed using a medicines list provided in letter format by the medical practice and not on a prescribed medication chart. Residents who are receiving respite care are usually managed by their own GP.</p> <p>The RNs and senior medication competent HCAs administer medications. All staff authorised to administer medicines complete an annual medication competency or when they contribute to a medication error. The RNs had completed current syringe driver competency and education. The medication policy supports residents, including young persons, to self-administer medicines if they wish. There were no residents self-administering medications on</p>

		audit days.
<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>	PA Low	<p>The manager oversees food provision at the facility. There is a commercial kitchen with all food prepared and cooked on site. The cook manages the food service. Food safety information and a kitchen manual are available in the kitchen. Kitchen staff did not all have current food safety training. There is a four weekly seasonal menu which has been reviewed by a dietitian. Interview with the manager identified application for registration of a food control plan had been completed.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. There were current copies of the residents' dietary profiles located in the kitchen. The personal food preferences of the residents, special diets/modified nutritional requirements are known to the cook and accommodated. Interview with the ACM and cook confirmed high protein drinks are supplied for those residents identified as being at risk of weight loss. Review of residents' monitoring records confirmed residents weights are documented monthly. Special equipment, to meet residents' nutritional needs was sighted. Food is served to the dining rooms and a tray service is available if requested. At time of audit two trays were observed to be hand delivered to the basement level external units.</p> <p>Records of temperature monitoring of food, fresh and frozen food on arrival, refrigerators and freezers are not always maintained. Electrical testing and tagging noted in relation to kitchen equipment had not been completed.</p> <p>Food audits are carried out as per the annual audit schedule. A cleaning schedule is maintained.</p> <p>Interviews with residents and families confirmed their satisfaction with the quality of the food service.</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>	FA	<p>The residents' needs are assessed prior to admission. The RNs and HCAs follow the care plan and report progress against the care plan on each shift at handover. Care planning does not always include specific interventions for both long-term and the short-term problems as per assessed needs (refer to 1.3.3.4). If external nursing or allied health advice is required, the RNs will initiate a referral (e.g. to the wound care nurse specialist, physiotherapist or podiatrist). If external medical advice is required, this is be actioned by the GP. Interview with the GP confirmed they are satisfied with the level of care provided. The GP stated the RNs refer problems in an appropriate and timely manner and that there is effective communication. The GP confirmed they provide 24 hour, 7 day a week support.</p> <p>Medical records document reviews, at least monthly or more frequently if needed. Nursing progress notes document any changes. Observation and weight charts are maintained. Assessments, monitoring and evaluation around pain were completed as indicated in the care plans. Specialist recommendations are followed up. There are adequate stocks of wound care and continence products.</p> <p>Staff interviews confirmed they are knowledgeable about the needs of the residents. Family communication is</p>

		recorded in the residents' files. In interviews, residents and family members reported residents' individual needs are met and they were actively involved in planning of care.
<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 facility provides an activities programme which reflects the residents' goals, ordinary patterns of life and includes normal community activities. Review of files evidenced residents' social history and their preferred activities are identified on admission. The activities coordinator plans monthly programmes which are then made available to all residents and their families.</p> <p>Residents are free to choose whether they wish to participate in the group activities. The physiotherapy assistant interviewed confirmed residents are assessed for mobility needs and assisted with group and personalised exercise programmes. Residents' participation in individual exercise programmes was evidenced on audit days. Residents are encouraged to maintain links with the community through outings with family and van outings organised by the activities coordinator. Birthdays and other special days are celebrated. Activities were observed during the days of audit. Younger person's specific activities include, but are not limited to, activities of choice and attending external activities of interest.</p> <p>Residents' attendance and participation is documented. Outcomes against goals are recorded. Evaluations are completed six monthly and there is evidence of resident and family participation. Resident meetings are conducted bimonthly and include discussion around activities.</p> <p>The residents and their families reported satisfaction with the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>Formal care plan evaluations occur every six months or as residents' needs change. Evaluations are carried out by the RN with input from the residents, family, HCAs, AC, physiotherapist and the GP. A short-term care plan is initiated for short-term concerns inconsistently (refer to 1.3.3.4). Review of residents' files evidenced additional input from specialists and other health professionals.</p> <p>Communication records evidenced families are notified of any changes in resident's condition. Residents and families interviewed confirmed their participation in care plan evaluations. Not all evaluations document progress towards meeting the desired outcome.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an</p>	FA	A current building warrant of fitness is displayed in a visible location at the entrance to the facility.

appropriate, accessible physical environment and facilities that are fit for their purpose.		
<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>The surveillance policy identifies the requirements around the surveillance of infections and includes the process for internal monitoring. Internal monitoring is completed via the internal audit programme. The ACM is also the infection control nurse (ICN). Infection data is collated monthly by the ICN. This data is analysed for trends and reported to the quality meetings, RN meetings and staff meetings.</p> <p>In interviews, staff confirmed they are made aware of any infections via the RNs, verbal handovers, short-term care plans and progress notes. Review of residents' files confirmed short-term care plans are in place for any infections. The ACM confirmed in interview there had 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>	FA	<p>St Patricks Home and Hospitals' restraint minimisation and safe practice handbook and policies comply with legislative requirements. Restraint is considered as a last resort. Enablers are voluntary and the least restrictive option is being used to maintain resident independence and safety. The restraint register and enabler register is maintained and current. There were no enablers in use and two restraints in use on audit days in the form of bed rails.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	PA Moderate	<p>Interviews with staff confirm they are aware of the policies and processes guiding safe use of restraint and alternatives to restraint use is considered prior to commencing restraint. Restraint documentation evidenced consent from an appropriate health professional. Review of restraint documentation showed that restraint assessments are not consistently completed and restraint risks are not recorded in the long-term care plan.</p> <p>The garden gate at the front of the property is locked for the safety of residents as stated in staff interviews. However, the rationale and processes for the use of this environmental restraint has not been recorded in the policy and processes. The previous requirements for improvement remain open.</p> <p>There is a restraint register in place maintained by the restraint coordinator. There have been no reported incidents related to unsafe restraint use. Interviews with staff confirm monitoring does occur, however, monitoring of the restraint is not documented in accordance with policy and the previous required improvement remains open.</p>

--	--	--

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)
<p>Criterion 1.1.10.4</p> <p>The service is able to demonstrate that written consent is obtained where required.</p>	<p>PA</p> <p>Moderate</p>	<p>The facility has surveillance cameras in the communal and external areas. Resident files identified that informed consent is signed for routine cares, the information to be collected; sharing of information with family; routine procedures to be carried out; visiting personnel/students and use of a photographs. However, the informed consent policy and consent forms signed by residents do not include the use of surveillance cameras in the communal and external areas of the facility.</p>	<p>i) Informed consent forms signed by residents do not include consent for the use of surveillance cameras.</p> <p>ii) The informed consent policy and procedure does not include guidelines for obtaining consent for the use of surveillance</p>	<p>i) Ensure informed consent forms include consent for the use of surveillance cameras.</p> <p>ii) Ensure the informed consent policy and procedure includes guidelines for obtaining consent for the use of surveillance cameras.</p>

			cameras.	90 days
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Staff meetings are held monthly and include quality, clinical updates, and health and safety. Meeting minutes are documented, however, corrective action plans do not always identify the person(s) responsible, timeframes for implementation or sign off. Internal audits are undertaken monthly. However, these did not consistently demonstrate that a timeframe identified for corrective actions or sign off once implemented.</p>	<p>i) The corrective action plans for meeting minutes do not consistently include identification of the person responsible.</p> <p>ii) The corrective action plans for meeting minutes and internal audits do not include timeframes for implementation of corrective actions or sign off after implementation of change.</p>	<p>i) Ensure corrective action plans for meeting minutes consistently include identification of the person responsible.</p> <p>ii) Ensure corrective action plans for meeting minutes and internal audits include timeframes for implementation of corrective actions and sign off after implementation of change.</p> <p>180 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Moderate	<p>Reported accident/incidents are investigated and closed out and there is evidence that corrective actions are implemented. Accident/incidents identified such as three wounds, a resident presenting with challenging behaviour and a resident experiencing a seizure were not documented on an incident form. Accident/incidents reviewed evidenced of 26 reported incidents, 13 related to resident</p>	<p>Not all incidents are documented on an accident/incident form.</p>	<p>Ensure all incidents/accidents are documented.</p> <p>90 days</p>

		falls (refer to 1.3.3.4).		
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Moderate	Staff files evidenced police checks were completed for some staff, however, this was not consistently completed for five of eight staff files. Performance appraisals were overdue in all staff files reviewed.	<p>i) Not all files demonstrate evidence of police vetting.</p> <p>ii) Performance appraisals are overdue for all staff.</p>	<p>i) Ensure all staff have current police vetting completed.</p> <p>ii) Ensure a performance appraisal is completed for all staff.</p> <p>180 days</p>
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA High	There is one RN on duty at all times, with occasions where RN numbers overlap (e.g. four hours over night and when the ACM is on duty). However, none of these staff are situated in the external units at basement level for oversight of residents in these areas. Four residents receiving hospital level of care are residing in these units. Two of these hospital level residents had suffered recent medical events, one of which required hospitalisation. There are two residents in these units, one at hospital level care, requiring overnight procedures. The external units do not currently include a nurses' station and RNs have to leave the main facility to attend to residents in these units, leaving 35 hospital level care residents in the main facility without an RN.	<p>i) The rationale document (skill mix policy and rosters) do not reference the processes and requirements for safe staffing relating to the layout of the facility and the external units.</p> <p>ii) Current registered nurse rostering does not assure care is accessible for all residents in a timely manner.</p>	<p>i) Ensure policy, guidelines and rosters reflect the additional need for oversight and service delivery in association with the layout of the facility for all residents, including the external units.</p> <p>ii) Ensure sufficient and accessible RN coverage is in place for all residents.</p> <p>30 days</p>

<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 Moderate</p>	<p>The medication room where medicines are stored in locked medicines trolleys is managed according to accepted medication legislation and guidelines. Review of dialysis fluids stored evidenced large quantities of dialysis fluids are not stored as per accepted guidelines for safe storage of medicines. There is an electronic medication management system in place. Medications are reviewed at least three monthly by the GP or sooner if required. Review of standing orders evidenced they were not current. The process for prescribing of respite medicines does not meet legislative requirements for correct prescribing of medicines.</p>	<p>i) Dialysis fluids are not stored in line with safe medicine safe storage practices.</p> <p>ii) Standing orders reviewed at time of audit are not current.</p> <p>iii) The current process for management of respite medications does not meet safe prescribing practice as per medication management legislation, acts and guidelines.</p>	<p>i) Ensure all medications is stored safely to comply with legislation, protocols, and guidelines.</p> <p>ii) Provide evidence standing orders are current and meet standing order legislative requirements.</p> <p>iii) Provide evidence the process for management of respite medications includes safe prescribing practice as per medication management legislation, acts and guidelines.</p> <p>90 days</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>PA Low</p>	<p>Staff interviewed in the kitchen were knowledgeable about their responsibilities in relation to food safety, however, not all staff in the kitchen had completed food safety training. Interview with the manager and cook stated food temperatures are monitored for; food on arrival, end cooked food, and refrigerator and</p>	<p>i) Monitoring of end cooked food, arrival of fresh and frozen, refrigerator and freezer temperatures</p>	<p>i) Provide evidence temperatures are documented as per requirements for all end cooked, fresh and frozen foods arriving,</p>

		<p>freezer temperatures. Review of records of temperature monitoring of fresh and frozen food on arrival, end cooked food, refrigerators and freezers were not always maintained. Interview with the manager and cook confirmed electrical testing and tagging is completed for the facility. However review of equipment in the kitchen evidenced electrical testing and tagging had not been completed for all equipment in use.</p>	<p>were not consistently documented.</p> <p>ii) Electrical testing and tagging of equipment in the kitchen had not been completed.</p> <p>iii) Kitchen staff had not all completed food safety training.</p>	<p>refrigerator and freezer units.</p> <p>ii) Provide evidence all equipment has been tested and tagged.</p> <p>iii) Provide evidence all kitchen staff have completed food safety training.</p> <p>90 days</p>
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Moderate</p>	<p>Services are coordinated in a manner that promotes continuity. Service delivery promotes a team approach. For two hospital level residents, including one residing in an external unit, long-term care plans were not reviewed after the latest interRAI assessment to promote appropriate service delivery. Not all long term care plans documented all interventions as assessed. Short-term care plans were completed for wounds and infections. A hospital level resident in living in an external unit did not have a short-term care plan for a recent medical event which required monitoring. Falls are reported and investigated in accordance with the accident/incident reporting process, however, in two of three there was inconsistent evidence of neurological observations being undertaken as stated in the facility's policy.</p>	<p>i) Long-term care plans evaluated six monthly were not always reviewed after interRAI assessment.</p> <p>ii) Long-term care plans not consistently document interventions for all current assessed needs.</p> <p>iii) Short-term care plans are not being used for the management of</p>	<p>i) Ensure all long-term care plans are reviewed after the interRAI assessment.</p> <p>ii) Ensure all long-term care plans document interventions for all current assessed needs.</p> <p>iii) Ensure short term care plans are completed for all acute/short term problems.</p> <p>iv) Ensure neurological observations are undertaken and</p>

			<p>all short-term/acute problems.</p> <p>iv) Not all residents who experienced an unwitnessed fall had documented neurological observations as per policy.</p>	<p>documented for all residents who experience an unwitnessed fall as per policy.</p> <p>90 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	<p>Long-term care plans are reviewed six monthly and signed by the RN and family member or resident as evidence of participation in care planning. Six monthly long-term care plan evaluations for two hospital level residents did not document the degree of achievement towards meeting desired goals and outcomes.</p>	<p>Evaluations do not always document achievement against goals and outcomes.</p>	<p>All care plan evaluations to document the degree of achievement against desired goals and outcomes.</p> <p>90 days</p>
<p>Criterion 2.2.3.2</p> <p>Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:</p> <p>(a) Only as a last resort to maintain the safety of consumers, service providers or others;</p> <p>(b) Following appropriate planning and preparation;</p> <p>(c) By the most appropriate health professional;</p>	PA Moderate	<p>Staff interviewed were aware of restraint documentation requirements. Relevant health professionals obtain consent for all restraints used and alternatives to restraint use is considered prior to commencing restraint. This was confirmed during interviews with ACM, RNs and restraint coordinator. However, review of files evidenced restraint assessments are not consistently completed. The restraint consent records reviewed included restraint risks, however, restraint risks are not documented in the long-term care plan.</p>	<p>i) Restraint assessments are not consistently recorded.</p> <p>ii) Restraint risks are not consistently recorded.</p> <p>iii) The environmental</p>	<p>i) Ensure restraint assessments are consistently recorded prior to the use of restraint.</p> <p>ii) Ensure restraint risks are recorded.</p> <p>iii) Ensure the environmental restraint (the lock</p>

<p>(d) When the environment is appropriate and safe for successful initiation; (e) When adequate resources are assembled to ensure safe initiation.</p>		<p>Interviews with staff confirm they keep the front gate locked (by a key pad) for safety of the residents. Access through the gate from the street is facilitated by a button on the street side of the gate. Visitors and family can access the code for the gate to exit from reception. The area at the gate is also the assembly point, should there be a fire or emergency evacuation. Staff stated that they will open the gate depending on the type of emergency. This lock is considered environmental restraint, however, the rationale and processes for use have not been recorded in their policy or processes.</p>	<p>restraint (the lock on the front gate) is not currently included in policy or procedures.</p>	<p>on the front gate) rationale is included in policy or procedures. 90 days</p>
<p>Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.</p>	<p>PA Moderate</p>	<p>Consent is obtained by an appropriate health professional. The restraint register is up-to-date, recording the residents' name, the type of restraint being used, when it was initiated and opportunity to record the date of when it is discontinued. Restraint monitoring occurs at the start and end of each shift, however, it is not consistently recorded at every check as per the restraint policy.</p>	<p>Restraint monitoring is not consistently recorded as documented in the restraint policy.</p>	<p>Ensure restraint monitoring to be completed at every check as documented in the restraint policy. 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.

No data to display

End of the report.