

# St Patrick's Home and Hospital Limited - St Patrick's Home and Hospital

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## 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:

<b>Legal entity:</b>	St Patrick's Home and Hospital Limited
<b>Premises audited:</b>	St Patrick's Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 19 April 2017    End date: 20 April 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	51



# Executive summary of the audit

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## 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
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

St Patrick's Home and Hospital can provide care for up to 60 residents. There were 51 residents at the facility on the first day of audit. This surveillance audit was conducted against the Health and Disability Service Standards and the service contract with the district health board.

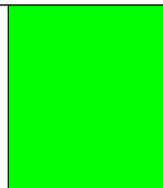
The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The facility manager is responsible for the overall management of the facility including clinical care and is supported by the acting clinical manager and two directors. Service delivery is monitored. Previous improvements from the certification audit have been closed.

Improvements required following this surveillance audit include; notification of statutory regulation requirements to the Ministry of Health; cleaning and chemical storage.

## 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.

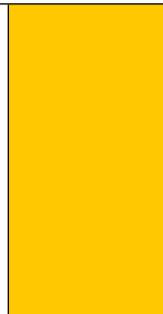
Information packs are provided to new residents and family members on entry to the service. Residents and family members confirm they are involved with review of the individual care plans. Family are updated if any changes occur in the resident's condition in a timely manner. Residents and family meetings are held monthly. Interpreter services are accessed when required and a multicultural staff mix enables interpretation to occur by staff where appropriate.

Communication occurs for staff using a communication book. Open communication between staff, residents and families is promoted, and confirmed.

A complaints register is maintained and up to date. Complaints are investigated within the required timeframes and documentation is maintained.

## 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 Patrick's Home and Hospital has a documented quality and risk management system. There is a document control process in place to manage policies.

There are human resource policies implemented including recruitment, selection and orientation. Staff receive education at orientation and as part of the ongoing training programme. Rosters are adjusted to meet numbers of residents in the facility and acuity levels. Staff are allocated to support residents as per their individual needs. Staff, residents and family confirm that staffing levels are adequate and residents and relatives have access to staff when needed.

## 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.
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Services are provided by qualified and skilled staff to meet the needs of the residents. All residents have an interRAI assessment performed. Timeframes for the development and review of long-term care plans are met. Short-term care plans are developed when there are changes in the resident's needs that are not addressed on the long-term care plan.

The general practitioner interviewed reviews all residents medically within the required timeframes and more frequently as required.

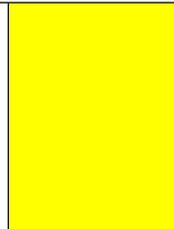
The activities programme meets the social and recreational needs of the residents. Activities are planned and are meaningful to residents. Residents are encouraged to maintain links with the community and their family/whānau.

A safe medication management system was observed during the audit. The staff responsible for medication management have completed competencies to perform this role. An electronic system is maintained.

The residents' nutritional requirements are met by the service with preferences and special diets catered for. Trained staff prepare meals and the menu plans are approved 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.



Some standards applicable to this service partially attained and of low risk.

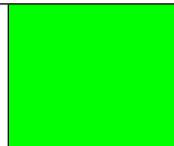
There is a current building warrant of fitness. A preventative and reactive maintenance programme includes equipment and electrical checks. Fixtures, fittings, floor and wall surfaces are made of accepted materials for this environment. There is a New Zealand Fire Service evacuation scheme in place.

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed in a timely manner.

## 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.

Policies, procedures and flow charts identify that enablers are voluntary and the least restrictive option to allow residents to maintain independence, comfort and safety. There were three lap belt restraints in use on audit days and no enablers in use.

## 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>
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The infection prevention and control management system is appropriate for the nature of the service. The risk of infection is reduced for residents, staff, families/whānau and visitors.

The acting clinical manager, who is the infection control coordinator, collates the monthly surveillance data and this is sent to a contracted infection control management service to report back on any trends and if any identified action is to be implemented. The infection surveillance results are reported to the registered nurses and the staff meetings held monthly. Expertise is always available and can be sought if and when required.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	17	0	1	1	0	0
<b>Criteria</b>	0	44	0	2	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>	FA	<p>Nursing staff and health care assistants interviewed demonstrated understanding of the principles and practice of informed consent. Informed consent policies and procedures provide relevant guidance to staff. The clinical records reviewed show that informed consent has been gained appropriately using the organisation's standard consent form, including consent for: photographs, treatment, outings/transportation and sharing health information. Transportation consent was added to the form utilised since the last audit.</p> <p>Advanced directives, advanced care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented where relevant in the individual resident's records. Staff demonstrated their understanding by being able to explain situations when this may occur. The areas of improvement identified in the last audit related to informed consent processes have been met.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and</p>	FA	<p>The organisation's complaints policy and procedures are in line with the Code and include periods for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; the outcome and agreed action.</p> <p>The complaints register includes documentation of verbal complaints. Evidence relating to each complaint</p>

<p>upheld.</p>		<p>lodged is held in the complaints folder. Complaints reviewed in 2017 indicated that the complaints are investigated promptly with the issues resolved in a timely manner.</p> <p>The facility manager is responsible for managing complaints. Residents and family confirmed that these are dealt with as soon as they are identified.</p> <p>Resident meetings are held monthly and residents and their families are able to raise any issues they have during these meetings, as confirmed during interviews. Projects have been completed as a result of identifying shortfalls through review of complaints, adverse events monitoring and suggestions from residents.</p> <p>There has been one complaint lodged with the Health and Disability Commission which has been closed.</p> <p>The requirement for improvement from the last audit has been closed out.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Information is provided to residents and their families as part of the information admission pack. The resident admission agreement, signed by residents or their representative on entry to the service, details information about the services that are included in service provision. Monthly resident meetings provide information and an opportunity for resident input.</p> <p>Open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and families. The residents' files reviewed provided evidence that communication with family members is documented in residents' records. There is evidence of communication with the general practitioner (GP) and family following adverse events.</p> <p>Residents in the rest home and hospital, as well as family members, confirmed that they are aware of the staff responsible for their care and that staff communicate well with them. The staff are multicultural and are able to assist with communication. The Chinese residents have a separate monthly meeting, facilitated by the Chinese speaking staff.</p> <p>Residents and family members stated they are kept informed about any changes to their relative's status, are advised in a timely manner about any incidents and outcomes of medical reviews. This was supported in residents' records reviewed. The improvement required from the last audit has been closed out.</p> <p>There was evidence of resident/family input into the care planning process. Staff interviewed demonstrated understanding of the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Health and Disability Commission Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Interpreter services are available through the district health board (DHB), if required. Staff knew how to access this service if needed but reported this was rarely required, as the facility has a multicultural staff mix,</p>

		which enables staff to act as interpreters. There are a number of residents for whom English is not their first language.
<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>	FA	<p>St Patricks Home and Hospital operates under the structure of two companies. There are values, goals and a philosophy documented in the strategic overview of the service. The strategic plan also includes a marketing plan and a strengths, weaknesses, opportunities, and threats analysis. These are communicated to residents, staff and family through information in booklets and in staff orientation and the web site.</p> <p>Two directors provide oversight of the service. The facility manager is a registered nurse with a current practising certificate and a Masters in Nursing. The facilities manager and acting clinical manager have been recently appointed to their roles.</p> <p>The facility can provide care for up to sixty residents with eight designated bedrooms for rest home level of care. Other bedrooms are designated as dual purpose beds (hospital and rest home). During the audit there were 51 residents living at the facility including 17 residents requiring rest home level of care and 34 residents requiring hospital level of care.</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>	FA	<p>The facility has a documented quality risk management framework incorporated in the business plan, to guide practice. The facility contracts an external consultant to provide policies that are linked to the Health and Disabilities Sector Standards, are applicable to legislation and evidenced based best practice. All policies are subject to review and are current. New and revised policies are presented to staff at staff meetings.</p> <p>There are monthly staff, quality, clinical and health and safety meetings. Meeting minutes evidence communication with staff regarding all aspects of quality improvement and risk management. All meetings have an agenda and minutes are maintained with the identification of people responsible for outcomes and timeframes. Clinical indicators and quality improvement data are recorded and staff are informed at staff meetings. Projects have been implemented as a result of the internal audit schedule.</p> <p>Service delivery is monitored through complaints management; review of incidents and accidents; surveillance of infections; pressure injuries; soft tissue/wounds; and implementation of an internal audit programme. The corrective action plans are documented and evidence resolution of issues completed. Internal audits are completed in line with the quality audit schedule, with evidence of corrective actions identified and implemented. There are monthly resident and family meetings coordinated by the diversional therapists.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed and risks minimised or isolated. Health and</p>

		<p>safety is audited monthly with a facility health check completed quarterly by the clinical and quality manager.</p> <p>The satisfaction survey for family and residents was completed in 2017 and reflects the satisfaction of the residents and family.</p> <p>The improvements required from the previous audit have been closed out.</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>PA Moderate</p>	<p>The facility manager is aware of some situations in which the service needs to report and notify statutory authorities, including police attending the facility, unexpected deaths, infectious disease outbreaks and changes in key managers, however, the manager was not fully aware of the requirements to notify pressure areas.</p> <p>The Ministry of Health and the district health board have been notified of changes in management roles.</p> <p>Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand elements of the adverse event reporting process and are able to describe the importance of recording near misses.</p> <p>Incident/accident reports reviewed had a corresponding note in the progress notes to inform staff of the incident/accident. Information gathered around incidents and accidents is analysed with evidence of improvements put in place. Incident/accident reports are signed off by the facilities manager.</p> <p>Improvements required from the previous audit have been closed out.</p> <p>An improvement is required in statutory and regulatory notifications.</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>FA</p>	<p>Human resource policies and processes are in place and implemented. All registered nurses (RNs) hold current annual practising certificates and visiting practitioners' practising certificates reviewed were current and include: general practitioners; pharmacists; dietitian; podiatrist; and physiotherapist. Staff files include employment documentation such as: job descriptions; contracts; and appointment documentation on file. Police and drug checks are completed and an annual appraisal process is in place with all applicable staff having a current performance appraisal.</p> <p>All staff have completed a comprehensive orientation programme. Staff are able to articulate the buddy system that is in place and that the competency sign off process is completed.</p> <p>Mandatory training is identified on a training schedule. A training and competency file is held for all staff, with folders of attendance records and training with electronic documentation of all training maintained. The service has a varied approach to ensuring that staff receive annual training that includes attendance at training sessions and annual individualised training around core topics. The training register and training</p>

		<p>attendance sheets demonstrate staff completion of annual medication and competencies.</p> <p>Four of the five registered nurses (including the facility manager) have completed interRAI training and one other registered nurse is currently completing the training. Staff have completed training around pressure injuries in 2017.</p> <p>The improvement required from the previous audit has been closed out.</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>	FA	<p>The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy.</p> <p>There are 43 staff, including clinical staff, staff who facilitate the activities programme and household staff. There is always a registered nurse (RN) on each shift. The manager (RN) and assistant manager are on call. If the manager is on leave, a senior RN takes the on call role.</p> <p>Evidence reviewed and observations confirmed residents requiring hospital level of care were well supported with a RN on duty at all times. Residents requiring rest home level of care were encouraged to be as independent as possible. Residents and families interviewed confirm staffing is adequate to meet the residents' needs.</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>The medication management policy is current and identifies a medicine management system in line with legislation and the Medicine Care Guide for Residential Aged Care.</p> <p>Safe medicine management using an electronic system was observed on the day of the audit that meets legislative requirements. The staff observed demonstrated knowledge and a clear understanding of the role and responsibilities related to each stage of medicine management. All staff who administer or assist with medicines are competent to perform the function they manage. Competencies are completed annually and records are maintained.</p> <p>The medication records reviewed electronically contained a photograph of each resident for identification purposes on their individual record. This was an area identified for improvement from the previous audit which has been closed.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by the RNs against the prescription when delivered to the facility and at the time of administration. All medications sighted were within current use by dates. Any returns to the pharmacy are</p>

		<p>collected by the pharmacist and recorded.</p> <p>The records of temperatures for the medicine fridge and medication room reviewed were within the recommended range. The required three monthly GP review is consistently recorded electronically.</p> <p>There were no residents who self-administer medications at the time of the audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Any medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>No standing orders are used.</p>
<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>	<p>FA</p>	<p>The food service is provided on site by a cook and kitchen assistants and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian. Recommendations made at the time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures are monitored appropriately and recorded as part of the plan. The cooks and kitchen assistants have completed food hygiene training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a nutritional profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily menu plan. Special equipment, to meet residents' nutritional needs, is available.</p> <p>Designated clean and dirty areas were sighted.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms to ensure appropriate assistance is available to resident as needed.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely</p>	<p>FA</p>	<p>Documentation recorded using validated nursing assessments tools, such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, is used as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of the trained interRAI assessors on site. The previous area identified as requiring improvement has been closed.</p>

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<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>Documentation, observations and interviews verified the provision of care provided to residents is consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of residents' individualised needs was evident in all areas of service provision. The GP interviewed, verified medical input is sought in a timely manner, medical orders are followed, and care has significantly improved with the newly appointed senior staff. Care staff confirmed care was provided as outlined in the documentation and interventions are included. A range of equipment and resources are available, suitable to the level of care provided and in accordance with residents' needs. The previous area of improvement has been closed.</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 activities programme is provided by a diversional therapist who has been in the role since September 2016 and an activities coordinator with eight years of experience in aged care settings. Both were interviewed and fully explained the activities programme. A social history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. The social history is completed with the resident and the family. These are used when planning the individual activities for a resident. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated six monthly as part of the six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group and one on one activities are offered. There are two vans to use for transportation, one of which is a full disability van with a wheelchair hoist. Three van outings are planned each week. The activities programme is discussed at the residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents care is evaluated on each shift and reported in the progress records. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six monthly interRAI reassessments or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans were consistently reviewed for example, wound care sighted and progress was evaluated as clinically indicated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is displayed. There have been no building modifications since the last audit although there has been refurbishment of rooms. The window on the second floor now has a latch, securing the window safely as it cannot open fully..</p> <p>Improvements from the previous audit have been closed out.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	PA Low	<p>Laundry is completed on site with covered laundry trolleys and bags in use for transport. There are designated clean and dirty areas in the laundry. Laundry staff are required to return linen to the rooms. Residents and family members state that their laundry is managed. The laundry staff interviewed confirmed knowledge of their role including management of any infectious linen.</p> <p>There are cleaners on site during the day, five days a week. Cleaning is monitored through the internal audit process completed quarterly. The environmental tour revealed areas that were not clean and areas that were an infection control risk. There are chemicals stored on shelves in both the sluices that were not locked. The cleaning trolleys are not stored in a locked area and during the audit trolleys were observed to be unsecure and unattended</p> <p>All chemicals are in appropriately labelled containers. Training around use of products is provided throughout the year.</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>Surveillance is appropriate to that recommended for long-term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. When an infection is identified, a record is documented on the infection reporting form. The infection surveillance records are collated and analysed monthly by the acting clinical manager to identify any trends, possible causative factors and required actions. The information is forwarded to an external contracted infection prevention and control consulting group who produce graphs and comparative summaries from the previous month. The data is benchmarked against other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>Information is shared with firstly the RNs at the RN meetings held monthly and then to staff through the communication book and staff meetings. Any new infections are discussed with staff at time of handover between shifts to ensure early intervention occurs. Expert advice can be sought from the contracted service, the microbiologist at the laboratory, the GP and/or the DHB infection prevention and control nurse advisors</p>

		<p>and infectious disease specialists if required.</p> <p>The infection prevention and control programme is appropriate for the size and nature of this service. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies, procedures and a flow chart meet the requirements of the restraint minimisation and safe practice standards and provide guidance for staff on the safe use of both restraints and enablers. The restraint coordinator was not present on the day of the audit. The restraint coordinator provides support and oversight for enabler and restraint management in the facility. The acting clinical manager verified that the coordinator demonstrates understanding of the organisation's policies, procedures and practice and the responsibilities of the role.</p> <p>On the day of the audit there were no enablers in use and three restraints (three lap belts) were in use. A similar process is followed for the use of enablers as is used for restraints. This provides for a robust process which ensures the ongoing safety and wellbeing of the resident.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident in interviews with staff, on review of the restraint approval group minutes and in files reviewed of those residents who have approved restraints.</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 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	PA Moderate	The facility manager had knowledge of some areas of their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.	Section 31 forms were not completed for one grade four pressure injury.	<p>The facilities manager must ensure appropriate documentation is completed to meet the statutory and regulatory reporting obligations.</p> <p>30 days</p>
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	PA Low	A cleaning audit is completed four monthly. There is a cleaning schedule and training for product use is in place.	The visual inspection of the environment did not reflect the cleaning audit schedule.	<p>Ensure more regular cleaning audits are implemented and a cleaning schedule is adhered to.</p> <p>90 days</p>
Criterion 1.4.6.3	PA Low	There are no designated areas for the safe and hygienic storage of cleaning	Chemicals are stored on shelves in the	Ensure all chemicals are

<p>Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.</p>		<p>equipment, chemicals and cleaning trolleys.</p>	<p>unlocked sluice rooms and cleaning trolley were left unattended.</p>	<p>safely stored.  30 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.