

Nazareth Care Charitable Trust - Nazareth House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Nazareth Care Charitable Trust

Premises audited: Nazareth House

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 15 August 2017 End date: 16 August 2017

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: 75

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
	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

Nazareth House, otherwise known as the Nazareth Community of Care, provides rest home and hospital level care for up to 80 residents. The service is operated by the Sisters of Nazareth Australasia and managed at the regional level by a general manager and a care services manager. Residents and families spoke positively about the care provided within this new facility.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, contracted allied health providers and a general practitioner.

This audit has resulted in two areas of continuous improvement related to implementation of quality management systems and identified three areas requiring improvement relating to staff training for new support workers, the need for the service agreement to meet contractual requirements, and that all residents' documented goals are individualised and specific.

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.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

There is a strong culture around recording, investigating and following up on feedback, which is consistent with the organisational policy on compliments and complaints. A complaints register demonstrated that actions and follow-up is occurring within expected timeframes.

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 low risk.
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Nazareth House, Christchurch, has a Christian based philosophy and its values and mission statement are documented. A strategic business plan and quality policies include measurable goals and objectives that are regularly monitored. An experienced and suitably qualified general manager manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. An electronic recording and monitoring system is used to improve implementation of the quality and risk management system. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery. Requirements for staffing levels and skill mix are documented and are amended according to the needs of residents at any given point in time.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

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 low risk.</p>
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

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.
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Waste and hazardous substances are well managed within this facility and chemicals are stored safely. Staff use protective equipment and clothing when appropriate.

The facility is new, clean and well maintained. It has been designed to meet the needs of people requiring rest home and hospital care. There is a current Code of Compliance on display. Electrical equipment and essential equipment, such as for fire warning and emergency management, is tested as required.

All internal areas are maintained at a comfortable temperature. Residents' rooms are spacious, have an openable window and have ensuite toilet and bathroom facilities. Communal and whanau rooms are available, as are smaller individual sitting areas for privacy. External areas are accessible, safe and provide shade and seating.

Laundry and cleaning are undertaken according to documented schedules. On-site laundry services are available and both cleaning and laundry processes are evaluated for effectiveness as part of the internal audit schedule.

Suitable emergency supplies are available. Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular six-monthly fire evacuation drills. A call bell system is in place and initial operational problems have been addressed. There are a range of systems that have been implemented to ensure security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler and six restraints were in use at the time of audit. Comprehensive assessments, approvals and monitoring processes are occurring according to policy documents, and a monthly review system is in place. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	47	0	3	0	0	0
Criteria	2	96	0	3	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Nazareth House has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Staff provided examples of the involvement of Advocacy Services in relation to staff training.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The compliments and complaints (feedback) policy and associated forms meet the requirements of Right 10 of the Code. This notes that verbal complaints are to be formally reported and that all complaints will be analysed with the resulting information used for continuous improvement when appropriate. The policy provides information and details on accessing advocacy services, information about the complaints process and states the timeframes for different stages of reporting during the follow-up process.</p> <p>The care services manager is responsible for complaints management and follow up. A complaints register is electronic and a review of this demonstrated there was a strong culture of recording complaints. There was evidence that verbally expressed low levels of dissatisfaction had been recorded and investigated. Complaints were reviewed and a sample were traced. The documentation showed that actions have been taken when relevant and that follow through to an agreed resolution had occurred within expected timeframes. Action plans show follow up and improvements have been made.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. Information on the complaint process is provided to residents and families on admission and those interviewed knew who to talk to and how to provide feedback. Such knowledge was further confirmed in the residents and family survey results.</p> <p>There have been no complaints received from external sources since the service opened.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with management. The Code is displayed in the entrance and communal areas together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by attending community activities, arranging their own visits to the doctor. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. There were no residents who identified as Māori at the time of the audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural,</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. For example, one resident with specific cultural requirements has this identified in her well-being and lifestyle care plan. The resident satisfaction survey confirmed that individual needs are being met.</p>

spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, palliative care team, diabetes nurse specialist, wound nurse specialist, and education of staff. The service employs a physiotherapist who assesses all new residents on admission to the facility and ongoing as required. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required. There was one resident with limited English and family members and communication cards were the preferred method of communication.</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</p>	FA	<p>An organisational chart for Nazareth House in Christchurch was sighted along with a number of others that show where this facility sits within the wider Australasian Nazareth Care Sisters of Nazareth services. Nazareth Care Australasia, established 2010, is the business arm of the Congregation of the Sisters of Nazareth. They have six values: Love, Compassion, Patience, Justice, Respect and Hospitality.</p>

<p>consumers.</p>		<p>The region comprises two governance structures, one of which is the Nazareth Care Australia Board, and the other is the Trustees of the Nazareth Care Charitable Trust in New Zealand. Board members work as a single board as a way of enhancing the governance of all Nazareth Care services across Australia and New Zealand. 'The Nazareth Way' is said to underpin services delivered and associated documentation about this concept is that it is Christian based, person centred and that they strive for excellence in their practice with everything that is done coming from the heart of who they are. The Mission of the Sisters of Nazareth and of Nazareth Care describes the Christian nature of their ministries of care and education and their openness to respond to the needs of the times.</p> <p>The business plan describes seven outcomes under the result areas of their mission, practice, people, relationships, infrastructure, property and sustainability. Milestones under each heading are documented. A 'congregational plan' for the Sisters, that further describes their values and ethos, was also sighted. The strategic business plan 2013–2018 is regional and a Christchurch specific section was added in 2013. This is reviewed annually and described annual and longer term objectives and the associated operational plans. A sample of monthly reports to the Chief Executive Officer in Australia, who extracts information for board reports, was sighted. The reports included information that demonstrates financial performance, emerging risks and current issues are being monitored.</p> <p>A general manager, who has been in the role since January 2017, is responsible for management of the Christchurch Nazareth House. This person has suitable skills and attributes with 10 years' experience in the management of aged care facilities in New Zealand and in the wider health field. She is a registered nurse (Masters of Nursing) with a current practising certificate and a post graduate Diploma in Management. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The general manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing professional development.</p> <p>The service holds four contracts with service agreements covering Aged Related Residential Care Agreement, young people with disabilities (YPD), palliative care and respite care. On the day of audit, there were 75 of the 80 swing beds occupied, with 33 rest home and 37 hospital level care residents; two YPD; two end of life/palliative care and one respite bed.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures</p>	<p>FA</p>	<p>In the absence of the general manager, the Sister Superior who is the mission and pastoral director, alongside the care services manager, jointly carries out all the required duties under delegated authority. Both of these people are registered nurses, are experienced in the sector, understand the mission and philosophy of the service and are able to take responsibility for any clinical issues that may arise.</p> <p>All managers have access to advice and support from the regional office in Australia. The general</p>

<p>the provision of timely, appropriate, and safe services to consumers.</p>		<p>manager stated that she does not go on leave at the same time as the care services manager. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>A diagram illustrates the nine key facets of the Nazareth Care quality management system, which includes feedback, legislation, clinical governance, meetings, risk management, resident information, staff information, continuous improvement, and key performance indicators. Expectations of the system and key responsibilities of managers are described within a quality systems policy, which also outline expectations, principles, procedures and the documentation involved in ensuring a consistent approach to the management of quality systems. Four goals around resident involvement, managing risks, providing effective human resources and striving to provide excellent clinical care have related objectives and management controls with each objective identifying who is responsible and what measures are to be used for evaluation.</p> <p>Policies and procedures reviewed cover all necessary aspects of the service and contractual requirements, including reference to management of pressure injuries, the interRAI Long Term Care Facility (LTCF) assessment tool and process. The document control system promotes a systematic two-yearly review process, ensures the referencing of relevant sources and that all organisational documents are approved and current.</p> <p>Incidents, complaints, audit activities, a family and patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint use are examples of the key components within the quality and risk system. A meeting schedule showed how regular reporting systems at all levels of the organisation are enabling ongoing monitoring of the quality management system. Meeting minutes reviewed confirmed regular review and analysis of quality indicators is occurring and that related information is reported and discussed at the various meetings. A specialised electronic system is being used to record quality data and the consistency and commitment to the analysis and review of the data from key components of the quality and risk management system is occurring at a level of continuous improvement. Likewise, the development of corrective action plans as quality improvements is occurring at a level of continuous improvement with all such actions aimed to improve management and residents' life experiences.</p> <p>Staff confirmed during interview that they are required to read meeting minutes, to complete reports such as incidents/accidents and infections and are involved in assisting with improvements within the service. Those interviewed were aware of how the different components of the quality and risk management system were managed, albeit they are not always directly involved.</p> <p>The care services manager and the general manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. This is occurring at all levels of the quality management system, in particular the analysis and review processes, and is a</p>

		<p>component of all quality improvement plans. Individual risks are managed through service delivery plans and in residents' risk management plans. The managers are familiar with the Health and Safety at Work Act (2015) and have implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The general manager and clinical services described essential notification reporting requirements, including for pressure injuries. They advised there has not been a need for any essential notifications to be made to the Ministry of Health, or other authority as there has not been any police investigations, coroner's inquests, issues based audits or significant events.</p> <p>Staff document adverse and near miss events on an incident form, which are then filed into the relevant resident's, or staff person's file. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed up in a timely manner. Adverse event data is collated, analysed and reported through the quality and risk group monthly meetings. Quality improvement initiatives are developed when indicated and examples of the implementation of these were sighted, as noted within the continuous improvement under criterion 1.2.3.8.</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 Low</p>	<p>Validation of qualifications of health professionals who are employed or contracted by Nazareth House is occurring. Records of annual practising certificates were sighted in staff and contractor files.</p> <p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process, which is primarily coordinated by the human resources department in Australia, includes formal advertising, application and interview processes, referee checks and police vetting. Interviews are undertaken by the Sister Superior and the line manager for the vacant position. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>A staff orientation process is in place and includes all necessary components relevant to the new person's role. Staff reported that the orientation prepared them well for their role and stated that they believe new employees that have been taken on since the opening are being adequately orientated. There is a comprehensive orientation guide available for staff and an orientation checklist is completed and placed in the staff person's file. A four-day orientation that included emergency management and relevant competencies was provided for all new staff prior to the facility opening in November 2016 and records of staff participation in these were sighted. Although there was evidence that formal employment processes occur after three months, staff records do not include staff appraisals as this service has not yet been operating for a year.</p>

		<p>An annual training plan called 'Empowered by Learning 2017' was sighted and includes topics for mandatory training requirements to be provided by both external and internal experts. The plan demonstrates that this staff training is provided two to three times a month and includes topics such as behaviours that challenge the norm, culture, the Treaty of Waitangi and end of life care for example. A number of care staff who were employed when the service commenced had already completed or commenced a New Zealand Qualification Authority education programme that met the requirements of the provider's agreement with the DHB. However, there is not currently a process in place to ensure new personal care workers staff are entering such a programme and this has been raised for corrective action. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated there is access to external training for all staff.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a policy on staffing rationale in the organisational folder. This describes minimum staffing numbers and the expectations of different groups of staff to meet residents' needs in a safe manner, 24 hours a day on seven days a week.</p> <p>The facility adjusts staffing levels to meet the changing needs of residents and examples of this were viewed with additional staff being rostered in two instances when residents required end of life care. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. All registered nurses have a current first aid certificate and there is registered nurse cover on all shifts.</p> <p>Observations and review of the rosters covering six weeks confirmed adequate staff cover had been provided, with staff replaced in any unplanned absence. The master roster has a two-weekly rotation and is entered electronically into 'Roster-On' by the general manager. Annual leave and gaps were colour coded, as were the ground and upper floor staff. Personal care workers reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this and were positive about the capability of the staff at Nazareth House.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p>

		Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	PA Low	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Not all exclusions in the admission agreement comply with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHBs 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility confirmed this process. Family of the resident reported being kept well informed during the transfer of their relative.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly and on request. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly

		<p>stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review was consistently recorded on the medicine chart. Standing orders are used, were current and comply with guidelines.</p> <p>There were no residents self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner, should this be required.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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>	FA	<p>The food service is provided on site by a qualified chef, cooks and a kitchen team, 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 within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the district council. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</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 in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. The facility documents all enquiries into an Expression of Interest</p>

is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		and Declining Entry form. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low	Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and continence, 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 seven trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process. While goals are developed and included in the well-being and lifestyle care plan, these are generic and not specific to the assessed needs.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Care plans evidence service integration with progress notes, activities notes, and medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is very good. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities	FA	The activities programme is provided by one trained diversional therapist holding the National

<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>		<p>Certificate in Diversional Therapy, and two assistants.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly and as part of the formal six monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, satisfaction surveys. Residents interviewed confirmed they find the programme varied and interesting.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. 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 reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds, and falls. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to wound care specialist and palliative care team. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p>	<p>FA</p>	<p>Documented processes for the management of waste and infectious and hazardous substances are in place to guide staff. Appropriate signage is displayed where necessary. A contractor manages the removal of general waste from the premises, while an external company is contracted to supply and</p>

<p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>manage all chemicals and cleaning products. The company provides relevant training for staff and has provided the material safety data sheets that were available where chemicals are stored. Staff interviewed knew what to do should any chemical spill/event occur. Spill kits that manage three different types of chemical spills were sighted.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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>	<p>FA</p>	<p>A current Code of Compliance is on display and is current until 10 October 2017. Building, which is safely fenced is continuing on site and associated hazards have been identified.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Corridors are wide and both personal and communal rooms are spacious. Residents are encouraged to bring their own personal items in and this was evident.</p> <p>The testing and tagging of electrical equipment is current (10 July 2017) as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Likewise, calibration of bio medical equipment and weighing scales, which were all purchased new in 2016, is current until October 2017. A hazard register is available and staff reported efforts made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. Exposed aggregate paths through gardens make it easy for residents to walk through, or be pushed in wheelchairs. Shaded and sheltered areas are available.</p> <p>A maintenance schedule and a repair and maintenance register was sighted. This is being updated as required. Residents informed they are happy with the environment, although comments were made about all the space.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. An ensuite is attached to all residents' rooms and communal wheelchair accessible toilets are near the nurses' station both upstairs and downstairs and near the main lounge. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. One upstairs bathroom and one downstairs bathroom have an adjustable recliner 'sit-bath' in them. Lift-up arms are available beside all toilets. All rooms have overhead hoists as do the bathrooms.</p>

hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms are the same size, measure 25 square metres and provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There are storage rooms to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>A range of communal areas are available for residents to use and to engage in activities. Furniture is appropriate to the setting and residents' needs. Spacious dining rooms are both upstairs and downstairs. There is a medium sized television lounge both upstairs and downstairs between two wings. Two whanau rooms are positioned near the nurses' stations in addition to two smaller ones where people may go for some privacy if required. A smaller activities room is used for supervised activities such as cooking sessions and a large communal room is available for group activities and entertainment. There is a prayer/quiet room, a cinema and a café that provides community access.</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>	FA	<p>There is a suite of policies and procedures on cleaning and laundry that include equipment, pest control, spill kit management, personal protective equipment, laundry services, linen services and cleaning and equipment. Cleaning and laundry schedules were available.</p> <p>Laundry services are undertaken in an on-site laundry by dedicated laundry staff. It is specially designed with metred doses of chemicals and dirty to clean flow processes as well as pressing services. Commercial laundry equipment has been installed. Laundry staff demonstrated a sound knowledge of the laundry processes and during interview noted that there had not been any laundry based complaints. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small cleaning team and all members have received appropriate training. Chemicals were stored in lockable cupboards and were in appropriately labelled containers. Cleaning trolleys are designed with residents' safety in mind and have a lockable cabinet on them.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme at six monthly intervals.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response were available. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan dated 11 October 2016 was approved by the New Zealand Fire Service on 04 November 2016. A trial evacuation takes place six-monthly (February and August) with the most recent being on 7 August 2017. Records for the last three evacuations were sighted. Registered nurses, enrolled nurses, line managers, care services manager and clinical care coordinator who started 7 November 2016 received full warden training and full emergency management training. Staff commencing since have undertaken basic fire and emergency training during orientation and are required to undertake the next trial evacuation. Staff records demonstrated participation in these processes and staff interviewed confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted. A water storage tank (5000 litres) is located on site and there are three forms of back-up power for use in the event of an emergency. Emergency lighting is regularly tested and all civil defence supplies are checked six monthly as part of the internal audit system.</p> <p>A call bell system is in place and staff 'DECT' phones ring and vibrate when a person presses a bell for assistance. The general manager explained the difficulties they had had as the structure of the building has compromised its operations. Two repeaters have been installed and three weeks ago a display panel was set up. An electronic system records call bell response timeframes and the computer screens where these show up were sighted in the nursing stations. Call system audits of these records have been undertaken more frequently due to the problems that have emerged. Families and residents acknowledged the efforts the service provider has made to address the issues.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night. There are 44 closed circuit television security cameras installed around external areas of the building as well as in doorways and corridors only inside. Monitoring screens are in both nursing stations and the videos are retained for a predetermined timeframe.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light from openable external windows with security latches in situ. Doors in communal areas throughout the facility open onto a patio and outside garden, or a balcony.</p> <p>Heating is provided through a computerised building management system with water filled radiators in hallways and a ducted heat pump system. The property manager checks the temperatures throughout</p>

<p>that is maintained at a safe and comfortable temperature.</p>		<p>the building on a monthly basis. Areas of the facility were warm throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the DHB consultant as available. The infection control programme and manual are reviewed annually.</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the general manager, and tabled at the quality committee meeting. This committee includes the general manager, facility manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for one year. She has undertaken specific training in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in October 2016 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff</p>

<p>relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when three outbreaks occurred in the past eight months.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing and advice about remaining in their room if they are unwell.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager, quality, IPC committee and included in the report to CEO. Data is benchmarked externally within the organisation. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>A summary report for a recent gastrointestinal infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</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>Restraint minimisation and safe practice policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers.</p> <p>On the day of audit, six residents were using restraints and one residents was using an enabler. These included two brief/groin restraints, a 'princess chair', a chair lap tray, a bedrail and two wheelchair lap belts, one of which was the enabler.</p> <p>The documentation and processes in use are the same for both enablers and restraints as the care services manager informed the associated risks were perceived to be similar. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the residents' files, reviews within the restraint register folder and through staff interviews.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>A restraint coordinator provides support and oversight for the use and management of enabler and restraint use in the facility and demonstrated an understanding both of the requirements around their use and of her responsibilities. The roles and responsibilities of the restraint approval group (within quality and risk group), the restraint coordinator and the employer are described in the policy documents.</p> <p>The restraint approval group is the quality and risk management group and is responsible for the final approval of the use of restraints and for the restraint use processes. It was evident from the restraint coordinator's restraint management records, review of quality and risk meeting minutes and an interview with the care services manager and restraint coordinator that there are clear lines of accountability that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau involvement in the decision making was on file in each case. Use of a restraint, or an enabler, is included in the resident's plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the standard. A registered nurse, in consultation with the care services manager undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The care services manager and the restraint coordinator described the documented process and records sighted showed that a general practitioner is involved in the final decision on the safety of the use of the restraint and signs the document accordingly. Assessment processes have identified the underlying cause of the behaviours, history of restraint use and cultural considerations. Alternatives have been trialled and associated risks identified and documented. Resident's safety and security was reported as</p>

		the primary purpose of the use of any form of restraint. Completed assessments were sighted in the records of all residents who were currently using a restraint or an enabler.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>The use of restraints is actively minimised and the care services manager described how alternatives to restraints, such as sensor mats and lowering the bed, are trialled and discussed with staff and family members.</p> <p>When restraints are in use, two hourly monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at monthly quality and risk group meetings. The register was reviewed and contained details of the restraints currently in use. There was sufficient associated information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Reviews of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews and at monthly clinical registered nurse meetings. Monthly reviews are led by the restraint coordinator. Families interviewed confirmed their involvement in the evaluation processes.</p> <p>Reports on restraint use are provided to quality and risk meetings for review purposes and consistency with the organisation's policies and procedures is checked.</p> <p>The evaluations of restraint use cover all requirements of the standard, including future options to eliminate use, impact of the use of the restraint for the person(s) and on the staff. Internal audits of residents' records included evaluation of the completion of restraint documentation.</p>
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of	FA	<p>Monthly reviews of all restraint use are occurring and being reported to quality and risk meetings when data analysis and evaluation occurs and checks for any trends are made. The general manager provides monthly reports to the Chief Executive Officer, which include details of the use of restraints. This information is compared with that provided by the Australian counterparts of Nazareth House, which may influence future decisions and approaches taken. For example, a stronger focus on ensuring</p>

their use of restraint.		staff are educated on de-escalation arose as a result of reports on restraint use. The care services manager discussed some of the factors within the facility that influence restraint use.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>A copy of the annual training plan called ‘Empowered by Learning 2017’ was sighted. This includes topics that meet mandatory training requirements and enables staff to attend ongoing paid training opportunities. A comprehensive orientation programme is also in place.</p> <p>Prior to the opening of this facility in November 2016, all new personal care workers attended a four-day orientation. Of this group 22 had completed or partially completed their certificate in health disability and aged support. Eleven other staff had not commenced any training suitable for aged care support work. The orientation course covered the topics required in clause D17.6c (i to vii) of the Aged Related Residential Care service agreement.</p> <p>Despite reports of initial discussions between managers, personal care workers employed since the opening of Nazareth House have not completed the training within six months of employment as</p>	<p>The current training system does not ensure that new staff complete the specific training, as required in clause D17.6c (i to vii) of the Aged Related Residential Care Service Agreement, within six months of appointment.</p>	<p>All staff who will be in direct contact with the residents shall within six months of employment, complete education (or have completed education) that is related to older people, as detailed in clause D17.6c (i to vii) of the Aged Related Residential Care Service Agreement.</p> <p>180 days</p>

		required in the service agreement and nor is there currently a system in place for this to occur.		
<p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	PA Low	<p>Entry criteria, assessment and screening processes during entry to service are documented, meet timeframes and are clearly communicated to residents and/or families. Those interviewed verified they were satisfied with the admission process and were given time to review the admission agreement. However, not all exclusions listed in Nazareth House admission agreement comply with the Canterbury District Health Board (CDHB) Age Related Residential Care (ARRC) Services Agreement.</p>	<p>Nazareth House residential agreement does not completely align with ARRC agreement D14.1 regarding exclusions from service. The admission agreement includes in Clause 3 exclusions services that are available and funded, for example, dietetics (dietitian) and advocacy.</p> <p>The statement regarding exclusions of 'personal equipment aids' needs to be further clarified to meet the intent of the ARRC agreement.</p>	<p>Nazareth House admission agreement meets the requirements of the CDHB ARRC agreement in relation to exclusions from service D14.1.</p> <p>180 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Low	<p>Goals are developed in all sections of the long term care plan. However, the goals are generic and not specific to the problem identified.</p> <p>For example, one resident with a complex issue identified as 'diabetes', also has identified skin management relating to poor circulation secondary to diabetes. The goal in the section is "To ensure complex needs are managed in a safe, effective and timely manner". Another resident with diabetes and complex health needs, has the goal "The complex health needs are managed in an effective manner".</p> <p>Those residents with moderate and high risk for pressure injury have a goal "To maintain skin</p>	<p>There are generic goals set for residents with complex needs identified rather than specific goals related to the issue/assessed needs. The well-being and lifestyle plan developed for activities does not include the resident's goals.</p>	<p>The specific goals of residents are identified and documented to serve as a basis for care planning.</p> <p>180 days</p>

		integrity' or 'To ensure skin integrity is maintained". There are no goals identified on the wellbeing and lifestyle care plan – activity plans.		
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>All data related to the various monitoring systems, whether it be complaints, incident reports, infection control or internal audit results, for example, is entered into an efficient electronic recording system called AngelTrend. The system is being used in an exemplary manner to record, analyse and evaluate quality improvement data. A range of graphs are being developed from the analysed data and all data from Nazareth House Christchurch is being benchmarked and compared with similar Australian Nazareth facilities.</p> <p>The information is being entered into AngelTrend in a comprehensive manner and the system facilitates progressive reporting until the issue is resolved, or the quality plan has been completed and evaluated. The care services manager is utilising the information from the system towards developing excellent and well planned quality improvement initiatives that are primarily either improving management systems or the operational systems for service delivery. Issues documented within the system were traced through and each demonstrated the significant and high level impact on resident outcomes. One such example was the review of the call bell system to ensure residents receive timely responses. The issues were not just thoroughly investigated but every aspect reviewed and evaluated until the desired outcome achieved. Ongoing audits of automated data occur and all out of time responses continue to be</p>	<p>Quality improvement data is being collected, analysed and evaluated at a level of continuous improvement with consistent processing, attention to detail and an ongoing focus of quality improvement of organisational systems and operations, which is ultimately enhancing the care and support and the environment for the residents.</p>

		<p>followed up. AngelTrend has enabled thorough investigations into concerns over staffing levels, which has resulted in increased staff being rostered on when a person becomes unwell and ongoing monitoring to ensure staffing levels enable residents to consistently receive all the support they require. A third such example related to identifying the issues behind food temperatures not being warm enough and putting in systems and monitoring processes to ensure all residents, including those who require assistance receive hot food.</p> <p>Not only was there anecdotal evidence of the benefits of using AngelTrend, but the general manager provided copies of reports to the CEO and to the board that confirmed the benefits AngelTrend has brought to Nazareth Community of Care. The gains made and reported as a result of its use in Australia are being replicated at Nazareth House, Christchurch.</p> <p>The processing of quality improvement data, using the AngelTrend system, is a continuous improvement as not only has it increased the efficiency of managing data within the quality management system but residents are gaining. It is addressing a larger number of resident related issues, the outcomes are more robust and the resulting ongoing monitoring and evaluation implemented mean residents can be confident of the improvements being maintained.</p>	
<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>	<p>CI</p>	<p>Corrective action plans are being developed within the electronic quality management recording system of AngelTrend. These may commence with monitoring processes to determine the level of intervention required or be the result of a minor issue of concern or dissatisfaction. Each plan of action is time-framed with interim progress reports and reviews documented until the action is completed, the issue resolved or the extent of an issue confirmed. An evaluation date is set and the level of improvement determined. Records sighted showed that timeframes and reporting is being upheld. Such action plans are titled 'quality improvements' and are mini projects intended to ensure staff refocus less positive issues onto more positive progress. Each improvement is a project that is evaluated in its own right and evaluation reports on each were sighted.</p> <p>The detailed corrective action planning/quality improvement projects facilitated by the use of AngelTrend is operating at a level of continuous improvement and sits alongside the continuous improvement identified in 1.2.3.6. Meeting minutes and CEO reports note the benefits of using AngelTrend for corrective action follow-up. As noted in 1.2.3.6 detailed action plans and the evaluation of outcomes from the actions demonstrate benefits in multiple areas that enhance resident outcomes and in many cases are also preventing an escalation from occurring.</p>	<p>When the need for corrective action(s) are identified, Nazareth House commences comprehensive investigation and review processes that according to evaluation summaries are resulting in staff implementing quality improvements for purposes of improving management processes and enhancing the lives and experiences of residents. This is occurring at a level of continuous</p>

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End of the report.