

St Catherine's Rest Home Limited - St Catherine's Rest Home

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 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: St Catherine's Rest Home Limited

Premises audited: St Catherine's Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 30 October 2018 End date: 31 October 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 10

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

St Catherine's Rest Home provides care for up to 14 resident's requiring rest home level care.

St Catherine's is part of the charitable organisation overseen by the Sisters of Mercy Ministries New Zealand Trust Board. An executive manager has worked at St Catherine's for almost 20 years and is responsible for the care services provided at St Catherine's. There is a management agreement in place between St Catherine's Rest Home and the chief executive officer (CEO) of Mercy Healthcare.

This surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, a general practitioner, a contracted physiotherapist, management and staff. Residents confirmed during interview that all their needs and wants are met in a timely manner.

There are no areas identified for improvement at this audit. The three shortfalls at the previous audit related to informed consent, hot water temperature, and ensuring there is a staff member on duty with a current first aid certificate have all been fully addressed.

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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The service demonstrated that residents' rights to full and frank information and open disclosure principles are met. Staff are aware of how to access an independent interpreter service if required. Only competent residents can document advance directives or make a living will.

Complaints management is well documented. All processes are undertaken to meet the standard's requirements.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The organisation's philosophy, mission and vision statements are identified in the business and strategic plan. The executive manager ensures service planning covers business strategies for all aspects of service so the services offered meet residents' needs, legislation and good practice standards. The service also works to ensure the needs and values of the Sisters of Mercy are met.

The quality and risk system and processes are well integrated in practice and support effective, timely service delivery. The quality management systems include an internal audit programme, resident / family satisfaction surveys, staff satisfaction surveys, complaints management, compliments, incident / accident reporting, hazard identification and management, minimising the use of restraint, and infection surveillance. Quality and risk management activities and results are shared among management, staff, and

residents as appropriate. Corrective action planning is well documented. The executive manager formally reports monthly to the CEO of Mercy Healthcare and more frequently as appropriate.

No new staff have been employed since the last audit; however, there is a documented orientation programme for when required. Staff participate in relevant ongoing education. Applicable staff and contractors maintain current annual practising certificates. The service has a documented rationale for staffing. Staffing numbers, including registered nurse hours, exceeds contractual requirements.

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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The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The processes for assessment, planning, provision, evaluation, review and exit are provided within timeframes that safely meet the needs of the residents and contractual requirements.

All residents have interRAI assessments completed and individualised care plans related to this programme and other nursing assessments. When there are changes to the resident's needs, a short-term plan is developed, or the long-term plan reviewed and updated. All long-term care plans are evaluated at least three monthly.

The service provides planned activities meeting the needs and faith of the residents.

Meals are provided by the onsite kitchen, and individual dietary needs as well as food preferences are accommodated. The service has a five-week rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met.

A safe medicine administration system was observed at the time of audit. A process is in place to assess that staff involved with administering medicines are competent to do so.

Safe and appropriate environment

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

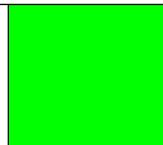


Standards applicable to this service fully attained.

The facility has a current building warrant of fitness. No changes have been made to the fire evacuation plan. The temperature of hot water is monitored in resident care areas and is within the required temperature range. A staff member with a current first aid certificate is on duty at all times.

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.

There were no restraint or enablers in use at the time of the audit. Staff are provided with annual education on restraint minimisation and the use of enablers and have current related competencies.

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.

The infection surveillance programme is relevant to the service setting. Infection information is collated, analysed and compared with previous data and actions are implemented to reduce infections. The infection surveillance results are reported and discussed at staff meetings and communicated to management.

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	18	0	0	0	0	0
Criteria	0	42	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.10: 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>Policies detail the requirements for advance directives or living wills and this aligns with current accepted practice. Only competent residents are able to make an advanced directive or living will. Residents are encouraged to document their wishes while competent. Advance directives were sighted in all residents' files where the resident was competent in decision making. In the event the resident was not competent, this was documented by the general practitioner. Residents are not charged for continence or wound supplies and this is no longer referenced as a possibility in the consent forms used.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>St Catherine's Rest Home implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with the Code of Health and Disability Services Consumers Rights' (the Code). During interview, residents, the executive manager, and staff verbalised their understanding of the complaints process and this aligned with organisation policy.</p> <p>A suggestions box is located outside the dining room. Concerns / complaints forms are readily available to residents / family.</p> <p>A complaints register is maintained, and associated records verified complaints are investigated and responded to in a timely manner. One complaint has been received</p>

		<p>since the last audit. This was investigated and responded to in a timely manner. There have been no complaints received from the District Health Board, Ministry of Health or Health and Disability Commissioner since the last audit.</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>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. All residents currently speak English. However, processes are in place to access interpreters if these are required. Pastoral care staff support residents and family attending hospital and other appointments where required.</p> <p>Evidence of timely open disclosure was documented in the residents' progress notes, accident/incident forms for applicable events. Residents confirmed they are kept well informed by staff of events / incidents and changing care needs.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>St Catherine's has a documented mission statement, philosophy and values that is focused around the provision of individualised, quality care in a peaceful, loving environment for women of Catholic faith.</p> <p>The executive manager monitors the progress in achieving these goals via a regular formal three-monthly review. The day to day operations and ensuring the wellbeing of residents is the responsibility of the executive manager (who is a registered nurse), with the support of two other registered nurses. A formal management service agreement is in place between St Catherine's Rest Home and the chief executive officer (CEO) of Mercy Healthcare Auckland Ltd (Mercy Healthcare). The executive manager reports formally on a monthly basis to the CEO and provides comprehensive written reports. The executive manager and the CEO of Mercy Healthcare identified they communicate more regularly if required, as both offices are located on the same floor. The executive manager is responsible for business and strategic planning for St Catherine's Rest Home. This includes wide consultation with the business and spiritual care stakeholders.</p> <p>The Mercy Healthcare CEO reports to a governance board on a regular basis, which in turns reports to an advisory group from the Sisters of Mercy Ministries Trust Board which is a charitable trust. Five of the Sisters of Mercy are trustees.</p> <p>Some renovations are occurring within the building where St Catherine's rest home is located. These changes do not involve the rest home area of the building.</p> <p>St Catherine's Rest Home has a contract with Auckland District Health Board for the provision of aged related residential care at rest home level of care. St Catherine's has 14 beds available. There were ten residents receiving care at the time of audit.</p>

		<p>The executive manager advises all residents have been assessed as requiring rest home level care. St Catherine's rest home is co-located in the same building as St Mary's convent. The three sisters currently living in the St Mary's convent live independently; however, are able to participate in the St Catherine's Rest Home activities programme and pastoral care programme, and have their meals provided by the St Catherine's kitchen.</p> <p>The executive manager is an experienced registered nurse, who has been in this or another senior management role at St Catherine's since 1998. The executive manager participates in relevant ongoing education as required to meet the provider's contract with ADHB. The executive manager has post graduate qualifications in business health management and economics, maintains a current annual practising certificate (APC), current interRAI competency, and participates in the ADHB aged care steering group meetings and aged related care 'cluster group' meetings. The executive manager is readily available to residents and family and this was observed at audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>St Catherine's Rest Home has a mature quality and risk management system which is understood and implemented by staff. This includes internal audits, resident and staff satisfaction surveys, incident and accident reporting, health and safety reporting, hazard management, infection surveillance data collection and management, restraint minimisation, monitoring the use of enablers, compliments, and complaints management.</p> <p>Policies and procedures were readily available for staff. Policies have been reviewed in a planned manner (every two years), by the executive manager or delegated staff. The executive manager is responsible for approving any changes prior to release and for document control processes.</p> <p>A comprehensive internal audit programme is implemented. The results of internal audits sampled demonstrated a high level of compliance with organisation policy. A registered nurse works clinically two days a week, and is also allocated one day a week as the continuous quality improvement (CQI) officer and infection prevention and control nurse. An annual review is undertaken of the previous year's quality and risk programme and outcomes (for period ending 31 March 2018).</p> <p>If an issue or deficit is found, a corrective action is put in place to address the situation. Corrective actions are developed and implemented and monitored for effectiveness.</p> <p>Meetings are held every two months with residents to obtain resident feedback on</p>

		<p>services and for future planning. There is good attendance, and the minutes of the last three meetings were reviewed. Topics included (but were not limited to) activities, staffing, the facility and meals. The results of the recent residents' satisfaction survey was very positive about staff and the services received.</p> <p>Quality information is shared with all staff via shift handover (where applicable), as well as via the continuous quality improvement / infection prevention and control meetings, the health and safety meetings and the staff meetings. These committees meet two monthly and are scheduled in a manner to ensure appropriate flow of information starting with the residents' committee meeting throughout the organisation. The minutes of the most recent meetings were displayed in the rest home staff office area. The minutes of the last three committee meetings were reviewed at audit and verified relevant information is communicated to staff. Staff interviewed verify they are kept well informed of quality and risk issues, changes and trends. The monthly infection, complaints and incident/accident summary data is displayed in the rest home office for recent years.</p> <p>Staff and residents interviewed expressed a high level of satisfaction about the services provided at St Catherine's Rest Home.</p> <p>Actual and potential risks are identified using the quality and risk planning processes. The electronic organisation risk register is extensive and showed regular monitoring (at least three monthly) of the organisation's risks. Colour coding is used to 'traffic light' risk for quick reference. Information is communicated to the Mercy Healthcare CEO and the Board. Clinical risk is also monitored with patient's weight and body mass index changes being monitored monthly and trended over time.</p> <p>New hazards are discussed, monitored and managed via the health and safety committee, and discussed at other relevant meetings. Staff confirmed that they understood and implemented documented hazard identification processes. The hazard registers sighted was last reviewed in May 2018. The hazard register for each room / service or environment is laminated and displayed on orange paper so it stands out on the wall, in each area for quick reference as observed during audit.</p> <p>The executive manager advises she keeps updated with legislative changes via existing peer networks.</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</p>	<p>FA</p>	<p>Policy and procedure details the required process for reporting incidents and accidents including near miss events. Staff are provided with education on the responsibilities for reporting and managing accidents and incidents during orientation and as a component of the November 2017 annual mandatory staff training /</p>

<p>to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>education programme.</p> <p>Applicable events are being reported on the designated forms in a timely manner and also disclosed to the resident and or designated next of kin / support person. This was verified by residents interviewed. A register of all reported events over time is maintained in each resident's clinical record. A review of reported events in sampled residents' files included falls, skin tear, a laboratory collection event, and a medicine error, demonstrated that incident reports are completed, investigated and responded to in a timely manner.</p> <p>The executive manager is on call after hours and is available to staff in the event of significant events or accidents / injuries to residents.</p> <p>Changes were made to the resident's care plan where applicable or a short term care plan developed where necessary. Staff advise they communicate incidents and events to oncoming staff via the verbal shift handover. The registered nurse interviewed advised the events / incidents are also summarised on the accumulative written shift handover report, to ensure ongoing communication with subsequent shifts. The general practitioner interviewed advised she is informed on resident incidents in a timely manner. The contracted physiotherapist also confirms being informed of resident falls in a timely manner.</p> <p>A summary of events were discussed with staff at the staff meetings and at the continuous quality improvement meetings. The number and type of incidents per month over several years was displayed on the staff notice board.</p> <p>The executive manager identified the type of events that must be reported to external agencies as an essential notification and advised there have been no events requiring essential notification since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Copies of the annual practising certificates (APCs) for two general practitioners (GPs), the pharmacist, the podiatrist, the dietitian, the executive manager and the two registered nurses (RNs) were sighted. Formal contracts are in place with the contractors. The APC and certificate verifying the visiting RN administering annual influenza vaccinations to staff and residents is an approved vaccinator is also on file. The 'licence to operate a pharmacy' for the contracted pharmacy was also sighted.</p> <p>Recruitment processes include completing an application form, conducting interviews and reference checks, and sampled staff files also contain a signed employment agreement. Police vetting commenced for staff employed during 2016 and has also occurred for the new allied health contractor. The executive manager advises no staff</p>

	<p>have been employed since the last audit. The caregivers advised the newest caregiver started at the end of 2016. Staff have signed job description on file which are reviewed and re-signed annually during the performance appraisal process. This includes reviewing the responsibilities for the two RNs that are allocated the responsibilities for the infection prevention and control, privacy and restraint minimisation portfolios. The job description includes a statement advising staff of privacy / confidentiality requirements. Annual performance appraisals have occurred in the applicable staff files sampled or were due / in process at the time of audit.</p> <p>Staff advise new employees have been required to complete an orientation programme relevant to their role. Records are retained in staff personnel files sampled. A checklist is utilised to ensure all relevant topics are included. New employees are buddied with senior staff for a number of shifts until the new employee is able to safely work on their own. A review is undertaken within three months of employment to identify any specific learning or other needs.</p> <p>An ongoing staff education programme is in place. An annual education study day is provided each year (last held in November 2017), that includes topics required to meet the provider's contract with ADHB and ensure staff competency. The study day is provided on two separate days to ensure all staff are able to attend. The topics included in the 2017 study day included (but were not limited to) complaints management, restraint minimisation, the use of enablers, managing challenging behaviours, fire safety, pressure injury prevention/management, manual handling and use of the hoists, falls prevention, and undertaking neurological observations and stoma care. Nineteen staff attended the 2017 day. There is some variation in content from year to year. The executive manager is currently developing the November 2018 programme. Staff are required to complete questionnaires following the annual study day as part of the education/competency assessment process, and the executive manager monitors to ensure that all staff complete the requirements. These records were sighted. Staff can also attend relevant external education. The executive manager and the registered nurses have recently attended a wound management study day.</p> <p>Records of education are maintained, and copies of some education certificates are present in the staff files reviewed. A number of caregivers interviewed have completed an industry approved qualification. The executive manager advises six staff have be enrolled to complete an industry approved qualification. Applicable staff will have one year starting November 2018 to complete the requirements. There is also an annual medicine and wound care competency programme. This includes oral medicines, blood glucose testing and management, eye and ear drops and</p>
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		nebulisers. All applicable staff have a current competency, with the re-assessment process for 2018 currently in process.
<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>A policy details staffing levels and skill mix requirements. The roster sighted demonstrated staffing exceeded the requirements of the provider's contract with Auckland District Health Board (ADHB). There are no staff vacancies.</p> <p>The current roster was reviewed and demonstrated that there is a RN on duty eight hours a day, seven days a week. This is shared between two RNs. The executive manager is also an RN and on site weekdays and on call when not on site. The executive manager and two other RNs have completed interRAI training and competencies. One RN is the CQI officer and responsible for the infection prevention and control programme. She is rostered 8 hours a week to undertake these responsibilities.</p> <p>A caregiver works weekdays 7am to 3pm, 3pm to 11pm, 4 pm to 9 pm and 11pm to 7 am. Another caregiver works week days 7am to 3pm undertaking caregiving duties for the initial part of the shift then facilitates the activities programme. On the weekends there is one caregiver on the morning, afternoon and night shift. Another caregiver works 7.30 to 11.30am and 4pm to 9 pm. Members of the pastoral care team support residents by taking them to offsite appointments.</p> <p>The activities facilitator has allocated time weekdays. She works part of the shift as a caregiver then progresses to facilitating the activities programme (refer to 1.3.7).</p> <p>The laundry is staffed two days a week (Wednesday and Fridays). A cleaner is rostered on duty 8 am to 4 pm Tuesday and Thursday. Caregiver staff assist with other cleaning throughout their shifts.</p> <p>Additional staff hours are rostered for the food / kitchen services. The kitchen also provides meals for Mercy Hospice and out catering. There is a cook / chef on duty each day 8.30 am to 5.30 pm. A kitchen assistant is on duty between 7 am to 2.30 pm, and another assistant from 2.30 pm to 7 pm every day.</p> <p>The contracted physiotherapist is on site weekly for four hours. The general practitioner routinely visits monthly, the podiatrist six weekly and a massage therapist also visits regularly.</p> <p>Eighteen staff have a current first aid certificate. There is always a staff member with a current first aid certificate and medicine competencies on duty.</p> <p>The staff confirmed the executive manager is available out of hours if required.</p>

		Residents interviewed confirmed their personal and other care needs are well met, they 'lack for nothing', and their call bells are answered very quickly.
<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 all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The residents interviewed verify they are informed of any changes in medicines and rational, as well as informed of medicines at the time of administration.</p> <p>A safe system for medicine management (using a paper-based system) was observed on the days 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.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These are checked on delivery against the medicine charts. All medications sighted were within current use by dates. Bottles of eye drops and inhalers have resident identification present. Pharmacist advice / input is provided on request.</p> <p>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 stock checks and accurate entries. The controlled drugs available are no longer required and are awaiting collection and disposal by the pharmacy.</p> <p>The records of temperatures for the medicine fridge were within the recommended range. No vaccines are stored on site.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. Administration records are clear and sample signatures of staff noted. Allergy assessments are consistently documented. Photographs are used to assist with resident identification. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are not used.</p> <p>One resident was self-administering one medication at the time of audit. The medicine is stored securely in the resident's rooms as observed during audit. The resident was confident in self-managing this medicine. The RN undertakes a monthly review to ensure the resident remains safe to self-administer this medicine, and the assessments are documented.</p>

		There is an implemented process for the reporting and management of any medication errors.
<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 employed staff and is in line with recognised nutritional guidelines for older people. Staff also provide meals to Mercy Hospice and for other functions / catering events. The five week menu follows summer and winter patterns. The winter menu is in use and this was reviewed by a registered dietitian in May 2018. 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 has lodged a food safety plan using the New Zealand Aged Care Association food control template with Auckland City Council in March 2018 and is awaiting the on-site review. Food temperatures are monitored appropriately and recorded as part of the plan.</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. This was verified by residents interviewed. Residents are encouraged to eat in the dining room. The residents that are able, can self-serve from the buffet. Staff assist any resident who requires help. Residents advise there is sufficient choices of food at meal times. A recent resident satisfaction survey provided positive feedback on food services. All residents are weighed at least monthly and their body mass index calculated. Variances up or down are closely monitored and acted upon where applicable as part of the clinical risk management programme. Nutritional supplements are available on site.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The focus on meeting a range of resident's individualised needs was evident in service provision. The GP interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and that staff provide good communication between residents, family and health professionals. Residents are seen six weekly by the podiatrist if necessary. Care staff confirmed that care was provided as outlined in the resident's file documentation and discussed at handover.</p> <p>A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</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>	<p>FA</p>	<p>The activities programme is overseen by a caregiver who works weekdays. The initial hours in the day till 10 am are caregiving. The caregiver facilitates the activities programme between 10 am and 11 am then 12 pm to 3 pm. The resident's attend mass at 11.15 am in the on-site chapel. There is also a library on site. The activities programme is displayed throughout the facility and in residents' bedrooms. The physiotherapist undertakes a weekly exercise class. On the weekend caregivers assist with facilitating some activities.</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 resident's individually and as a group. The resident's activity participation is monitored three weekly via the internal audit programme, and as part of the formal three-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included community and faith bases activities. Individual, group activities and regular events are offered. Residents are involved in evaluating and improving the programme through residents' meetings and day to day discussions. Residents interviewed confirmed they find the programme interactive, being able to maintain their independence and/or be supported with their day to day activities of living. The pastoral care team take the sisters on outings or to health or other appointments.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' care is evaluated and reported in the progress notes. If any change is noted, it is reported to the RN, or if significant, it is reported to the executive manager after hours.</p> <p>Detailed formal care plan evaluations occur every three months, and 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 and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents 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</p>	<p>FA</p>	<p>The facility has a current building warrant of fitness with an expiry of 2 June 2019. Hot water temperatures in resident rooms are being monitored on a rotating basis with a least three rooms checked each month. The temperatures are all within the required</p>

are fit for their purpose.		range. The shortfall from the last audit has been addressed. Building work is occurring within the building but is not within the area used for St Catherine's.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The fire evacuation plan has not required amendment. Fire drills are conducted at least six monthly. There have been multiple false fire alarms this year caused by the construction activities. A staff member with a current first aid certificate is on duty every shift. The shortfall from the last audit has been addressed.
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.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract, skin and soft tissue, vaginal, eye / ears, gastro-intestinal, the upper and lower respiratory tract and outbreaks. When an infection is identified, a record of this is documented on the resident infection incident log in the resident's clinical record. Any specimens sent to the laboratory are reported on by the laboratory utilised on a monthly printout. Any antibiotics are recorded as well on data reviewed. The clinical quality improvement officer is also the infection control coordinator. Monthly surveillance data is sent through to the executive manager and to the board. An annual analysis is also undertaken by the executive manager and compared with the year prior. Infection rates and risks are very low at this aged care facility. There have been no outbreaks since the last audit. Surveillance undertaken is appropriate for the size and nature of the service provided.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards. Restraint can only be considered if all other options have been considered. The restraint coordinator (the fulltime RN) provides support and oversight for enabler and restraint minimisation processes, and verbalised an understanding of the organisation's policies, procedures and practice, and the restraint minimisation coordinator role and responsibilities. Caregivers interviewed could describe enablers and restraints and verified these have not been used 'for some time'. On the day of audit, no residents were using either restraints or enablers. Staff have been provided with orientation and ongoing training on restraint minimisation and enabler use. In-service education occurred in November 2017 as part of the mandatory staff study day programme.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.