

St Patricks Limited - St Patricks Home and Hospital

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

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

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

The specifics of this audit included:

Legal entity:	St Patricks Limited
Premises audited:	St Patricks Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 15 January 2019 End date: 16 January 2019
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:	56

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 Patricks Rest home can provide services for up to 60 residents requiring rest home or hospital level care. There were 56 residents at the facility on the first day of the audit.

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

There were 10 areas identified as requiring improvement relating to: admission agreements; staffing; timeframes of service provision; progress note documentation; assessments; care planning; care plan interventions; care plan evaluations; kitchen services; and laundry.

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.		Some standards applicable to this service partially attained and of low risk.
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Information regarding the Health and Disability Commissioners' Code of Health and Disability Consumers' Rights; the complaints process; and the Health and Disability Advocacy Service is made available to residents and their families on or prior to admission. It is also accessible to residents and their families in the facility.

Staff interviews demonstrated an understanding of residents' rights and obligations. Residents and family members confirmed their rights are being met; staff are respectful of their needs and communication is appropriate.

Residents' cultural and spiritual beliefs are identified on admission and there is access to cultural and spiritual support if required. Informed consent is practised and written consent is obtained when required.

Services are provided that respect the independence, personal privacy, individual needs, and dignity of residents. Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse and neglect.

There is a documented complaints management system that aligns with Right 10 of the Health and Disability Commissioners' Code of Health and Disability Consumers' Rights. The manager is responsible for the management of complaints. Complaints are investigated and documented, with corrective actions implemented where required. A complaints register is maintained. There have been no complaints to external agencies since the last audit.

Staff communicate with residents and family members following any incident or change in condition and this recorded in the resident's file.

Residents, family and GP interviews confirmed that communication was appropriate and that staff are respectful of their needs. Services are provided that respect the independence, personal privacy, individual needs, and dignity of residents.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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St Patricks Home and Hospital is a New Zealand Limited Company. The manager and acting clinical manager are suitably qualified and have been in their roles for over one year.

The facility has a quality and risk management plan and system that supports the provision of clinical care and quality improvement at the facility. Policies are reviewed and current. Quality and risk performance are monitored through the organisation's reporting systems.

There is an implemented system to identify and record risk in which risks and controls are clearly documented. There is an implemented incident and accident management system to record and report adverse, unplanned or untoward events, including appropriate statutory and regulatory reporting.

The manager is a registered nurse and is responsible for the overall management of the facility and is supported by an acting clinical manager. The acting clinical manager is a registered nurse and is responsible for clinical management and oversight of services. The acting clinical manager is supported by a team of registered nurses.

Human resource policies and procedures guide practice and there is evidence that human resource processes are being followed. There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. Registered nurses are on duty seven days per week and are supported by care staff.

Systems are in place to ensure the consumer information management system is protected from unauthorised access.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The organisation works with the Needs Assessment and Service Coordination Service to ensure access to the services. Residents receive services from qualified staff. The registered nurses are responsible for completing the initial assessments, including interRAI, the initial care plans, the short-term care plans for acute conditions and the long-term care plans for long-term service delivery.

Residents are referred or transferred to other health services as required with appropriate verbal and written handovers.

The planned activities programmes are overseen by an activities coordinator. The programmes provide residents with a variety of individual and group activities and ensures residents are able to maintain their links with the community, including the young person with disabilities.

There is a medicine management system in place to ensure safe and appropriate processes for prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation. Staff responsible for medicine management have current competencies completed annually and attend medication management training and education. There were no residents self-administering medicines.

Menus meet national nutritional guidelines for older people. The service is using the template food plan. Residents' special dietary requirements and needs for assistance during feeding are met. Residents verified their 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.

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

There is a current building warrant of fitness. A planned, preventative and reactive maintenance programme is in place that complies with legislation and includes equipment and electrical checks.

The facility has a main building with rooms able to be used for double occupancy. In addition, there is a block of seven units and a cottage with four bedrooms. Bathroom and showering facilities are provided throughout the facility and are easily accessible. The facility has a call bell system for residents to summon help when needed and call bells were observed to be answered in a timely manner.

Essential security systems are in place to ensure resident safety with six monthly trial evacuations undertaken.

There are documented and implemented policies and procedures for cleaning and waste management. The laundry service is provided seven days per week and cleaning services are provided Monday to Friday.

Restraint minimisation and safe practice

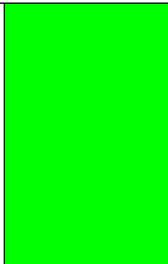
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Standards applicable to this service fully attained.

The restraint minimisation policy and the definitions of restraint and enabler are aligned with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety.

There were no residents using restraints and one resident requesting the use of an enabler on audit days.

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 acting clinical manager is the infection control coordinator. They are responsible for staff education in infection control and the surveillance of infections at the facility. New employees are provided with training in infection control practices and there is ongoing infection control education available for staff. Staff are familiar with infection control measures at the facility.

Infection surveillance is undertaken, analysed, trended, and results are 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	36	0	2	7	0	0
Criteria	0	83	0	2	8	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>St Patricks Home and Hospital (St Patricks) has implemented policies and procedures to ensure that services are provided in a manner that is consistent with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). Policy provides guidance to staff on how to promote independence, resident choice, and spiritual health.</p> <p>Staff receive education on the Code as part of orientation to the service and through the education programme. Staff interviews confirmed their understanding of the Code and their obligations. Evidence that the Code is implemented in their everyday practice includes maintaining residents' privacy; providing residents with choices; encouraging independence; involving residents and family in decision making and ensuring residents can practise their own personal values and beliefs.</p> <p>Residents and family interviews confirmed that services are provided in a manner that upholds resident dignity and maintains their privacy, and that they receive information relevant to their needs. Staff were observed to be respectful towards residents and their families.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are</p>	FA	<p>There is an informed consent process that aligns to the Code. It ensures that all residents are aware of treatment and interventions planned for them, that the resident and/or significant others are included in the planning of that care and can make their wishes, requirements and expectations</p>

<p>provided with the information they need to make informed choices and give informed consent.</p>		<p>known and to trust that these will be followed. It describes the procedure and responsibilities for obtaining informed consent and the obligations under the Code.</p> <p>The information pack provided on or prior to admission includes information regarding informed consent and the manager discusses this with residents and their families during the admission process to ensure understanding.</p> <p>Staff interviews confirmed an understanding of the informed consent process. Residents' files identified that informed consent is signed by residents or next of kin. It includes confirming that: consent has been explained, discussed and agreed; consent may be withdrawn; the resident continues to have choices regarding preferences for daily living; has been given a copy of the code; consent to the provision of health and wellbeing information to family; consent to influenza vaccination; and awareness of surveillance cameras in the communal and external areas of the facility.</p> <p>Admission agreements include information about informed consent (refer to 1.1.9.1).</p> <p>Resident and family interviews confirmed that consent is sought prior to the provision of services and treatment.</p> <p>Resuscitation/advanced directives are defined in informed consent policy.</p> <p>The resident signs acknowledging that they can change their decision at any time and that the directive will be reviewed six monthly. File reviews demonstrated that resuscitation and advance directives were signed by the competent resident.</p>
<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>St Patrick's has an advocacy policy that allows residents free access to the services of any independent advocate of their choice. It defines advocacy and its principles and details the procedures for advising of advocacy and obtaining advocacy services.</p> <p>Information regarding the availability of the Nationwide Health and Disability Advocacy Service is included in the information packs provided to residents and family on admission to the facility. Additional advocacy services brochures are available on the entrance to the facility. The complaints policy includes making residents aware of their right to advocacy when making a complaint.</p> <p>Staff and resident interviews confirmed that to advocates regularly visit the facility and external advocacy services can also be accessed on behalf of residents if required.</p> <p>Family and resident interviews confirmed that the facility provides opportunities for the family to be involved in decisions, they are aware of the right to advocacy and that advocates visit the facility.</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>Observation and resident and staff interviews confirmed that residents have access to visitors of their choice at any time. There are sufficient areas both inside and outside the facility for a resident and family to meet and socialise in private. Observation and interviews confirmed that families were made to feel welcome in the facility.</p> <p>Residents are encouraged to maintain existing community involvement with family and social networks. Resident interviews confirmed that residents are free to leave the facility when they so choose, for example, to go shopping; attend appointments; and family outings. The activities programme and the content of care plans include regular outings in the community.</p> <p>Resident interviews confirmed active enrolment in their community and attendance at family events, when they chose to. Interviews stated that the facility is responsive to the needs of young people with disabilities (YPD), encouraging access to activities and resources in the community if they wished.</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>There is a complaints policy that is in line with the Code and includes advocacy. It describes manager and staff responsibilities, outlines the complaints procedure and includes a flow chart of the process. The complaints and compliments form outlines the process for those completing a complaint form.</p> <p>The complaint process and forms are made available as part of the admission pack and complaint forms are available at the entrance to the facility.</p> <p>The manager is responsible for managing complaints. An up to date complaints register is in place that includes: the date the complaint is received; the source of the complaint; a description of the complaint; resolution and the date the complaint is signed off. Complaints reviewed indicated complaints are investigated promptly and issues are resolved in a timely manner.</p> <p>Residents and family interviews confirmed that they had been made aware of a complaints process and that they could make a complaint. Monthly resident meetings provide an opportunity for residents and their families to raise any issues or concerns. There is evidence that issues raised had been addressed as an opportunity for improvement.</p> <p>There have been no complaints lodged with the Health and Disability Commissioner (HDC) or other external authorities since the previous audit. One Health and Disability Commissioner's enquiry (January 2018) which was open at the previous audit has not been closed. The service provider were advised to contact HDC to follow up this complaint to determine whether there are any recommendations required to be implemented or if it is closed out by HDC.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>New residents and their families are provided with information about the Code as part of an information pack provided on admission to the facility. As part of the admission process, the manager also explains the Code to ensure understanding. The pack includes information on the complaints process and advocacy service.</p> <p>The Code and associated information is also available in information brochures which are displayed at the entry to the facility and available to take away and read in private. Information on the Code is also displayed in posters in the facility.</p> <p>The facility has two independent advocates. Manager interview advised that one of the advocates visits the facility weekly and is available to meet with residents on a one-to-one basis, to provide support and advocacy.</p> <p>Residents and family members interviewed were familiar with the Code and the advocacy service. Residents and family stated they would feel comfortable raising concerns or issues with staff and management.</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>	<p>FA</p>	<p>The organisation has policies and procedures that are aligned to the requirements of the Privacy Act and Health Information Privacy Code and ensure that a resident's right to privacy and dignity is upheld.</p> <p>Staff were observed to knock on bedroom doors prior to entering rooms and ensure that doors were shut when personal cares were being provided. Interviews and observation confirmed that conversations of a private or personal nature were held in the resident's room and not in public areas. Residents and families stated that they felt that resident privacy is respected.</p> <p>The organisation has a policy on sexuality and intimacy to ensure that a resident's dignity, confidentiality, and privacy is always maintained. It details for staff strategies for managing expressions of sexuality and steps to be taken in the advent of inappropriate sexual behaviour or assault. The independence and individuality policy aims to maximise resident independence for example encouraging a resident's own choice of clothing, toiletries and make-up.</p> <p>Resident files, interviews and satisfaction surveys confirmed that individual cultural, religious, social preferences, values and beliefs were identified, documented, and upheld.</p> <p>There is policy and guidelines for staff that aims to recognise and prevent abuse. It includes defines abuse and details how abuse will be reported, investigated and managed. Staff meetings provide an opportunity for discussions and training on identification and management of abuse and neglect. Staff interviews confirmed awareness of their obligations to report any incidences of suspected abuse. There are no documented incidents of abuse or neglect. Staff, resident, and family interviews</p>

		confirmed that there was no evidence of abuse or neglect.
<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>There is a business, quality risk and management plan that identifies St Patrick's commitment to providing services to Māori that are consistent with the Treaty of Waitangi. There is also a cultural safety and cultural responsiveness policy that provides guidelines for staff on the provision of culturally safe and responsive services for Māori residents.</p> <p>The chief executive officer (CEO)/maintenance person identifies as a Māori kaumātua/elder and is available to provide support for staff in providing culturally appropriate care, and for Māori residents and their families, if required. Staff receive training in cultural safety as part of the annual education programme. There was one resident identifying as Māori at the time of 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, spiritual values, and beliefs.</p>	FA	<p>Staff, resident and family interviews confirmed that residents are provided with choices regarding their care and the services provided, and that residents and family are involved in the assessment and the care planning processes.</p> <p>Information gathered during assessment includes identifying a resident's specific cultural needs, spiritual values, and beliefs. A review of residents' files confirmed that specific cultural needs identified in assessments are reflected in the residents' care plans. Assessments also include obtaining background information on a resident's spiritual and cultural preferences, which includes but is not limited to, beliefs; cultural identity; and spiritual beliefs. This information informs activities that are tailored to meet identified needs and preferences.</p> <p>There are regular visits from visiting priests/ministers of different denominations and monthly Anglican and Baptist church services for those wishing to attend.</p> <p>Resident interviews and surveys confirmed that the services were responsive to individual resident's cultural needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>There is a policy to ensure that residents are protected from discrimination, coercion, harassment and exploitation. The policy identifies staff training and guidance to prevent discrimination and responsibilities to ensure the appropriate action is taken where this is suspected.</p> <p>Staff are made aware of: their obligations under the Human Rights Act; St Patrick's code of ethics; and house rules as part of orientation. Staff interviews confirmed awareness of their obligations.</p> <p>There were no complaints or incidents recorded since the previous audit relating to any form of</p>

		<p>discrimination, coercion, harassment or exploitation. This was confirmed in staff, resident and family interviews.</p> <p>Resident and family interviews confirmed that staff maintain appropriate professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>St Patricks has a suite of policies and procedures which are current and based on good practice and current legislation and guidelines. The policies align with the Health and Disability Services Standards and support safe, current evidence-based practice.</p> <p>There are relevant training programmes for all staff. Interviews and training records confirmed that staff have access to external professional development. The organisation's quality framework includes an internal audit programme to ensure that service delivery complies with documented procedures.</p> <p>Staff, resident and family interviews, resident file notes and observation of service delivery confirmed that resident care was based on good practice guidelines.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Low	<p>There is an open disclosure policy that sets out the process to guide staff to ensure that there is frank discussion with a resident and their support person about any adverse event. This includes when the resident has suffered any unintended harm whilst receiving care or when an error has affected a resident's care even if it does not appear to have caused harm. Completed incident forms and resident records demonstrated that family are informed if the resident has an incident/accident; a change in health or a change in needs. Family contact is recorded in residents' files and on the incident form. Family and resident interviews confirmed that family are informed of any changes in resident status and that they are invited to the care planning meetings for the resident.</p> <p>The resident admission agreement, signed by residents or their representative on entry to the service, details information about services provision including any associated costs for additional services. Admission agreements are provided on entry to the service for residents and/or the families to sign. The manager discusses and explains the admission agreement with the resident and family. The agreement is only available in English. Admission agreements were not consistently signed by the resident or their family member within the required timeframes.</p> <p>Monthly resident meetings inform residents of facility activities and provide an opportunity to raise and discuss issues/concerns with management. These are advertised on notice at the entry to the facility and family are invited to attend the meetings. There are separate meetings held in Chinese and English speaking languages. Resident meetings minutes demonstrated that a range of topics are covered including but not limited to: new residents; new staff; food services; and upcoming activities. Family are also kept informed of events and activities through an electronic mobile phone application.</p>

		<p>Resident interviews confirmed that the manager and staff were available to discuss matters and responded promptly to any concerns raised.</p> <p>Observation and staff interviews confirmed that the facility has an 'open door' policy in line with quality policy and encourages ongoing communication with residents, relatives, visitors and staff in order to identify and respond to needs.</p> <p>There is policy to ensure that residents and family who do not use English as their first language are offered the availability of interpreting services. Interpreters can also be accessed externally through the district health board if required. At the time of the audit 33 of 56 residents identified as Chinese many of whom did not use English as their first language. Staff is made up of people from a range of ethnicities including, but is not limited to, Chinese and Pacific Island peoples who are able to communicate with residents in their preferred dialect. There are also boards with key phrases in both the resident's native language and English to facilitate communication, if required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>St Patricks has a documented: mission statement; philosophy; goals and objectives are displayed in the facility and detailed in the business, quality risk and management plan. The plan includes a risk analysis and quality planning. Goals and objectives are reviewed and reported annually by the manager and progress is discussed with the shareholders on an ongoing basis. The philosophy is also communicated to residents in a facility information booklet provided on admission.</p> <p>The facility is managed by a manager supported by an acting clinical manager (ACM) who have been in their current roles for one year. Both the manager and ACM are registered nurses (RN) with current practising certificates. The manager was previously the clinical manager of the facility and has two years' experience at St Patricks. The manager has a master's degree in nursing and previous experience with the district health board (DHB) working in rehabilitation services. Clinical care at the facility is overseen by the ACM. The ACM has previous experience in rehabilitation and as a clinical manager in aged residential care.</p> <p>The manager and ACM are two of the owners/directors of the facility. A third owner/director is identified as the chief executive officer (CEO) has a Master of Business Administration and qualifications and experience in the building industry. This director provides maintenance services for the facility and cultural support, however, is not involved in day to day management of the facility.</p> <p>The facility is certified to provide rest home and hospital level care and currently provides care for up to 60 residents. There are eight beds designated at rest home level and 52 as dual-purpose beds. There were 56 beds occupied at the time of the audit. Occupancy included 17 residents assessed as requiring rest home level care; and 37 assessed as requiring hospital level care. In addition, there was one person, assessed at hospital level care, under the YPD agreement and one person at rest home</p>

		<p>level care under a respite care contract. The facility has contracts with the DHB for the provision of rest home and hospital level care, palliative care; respite and YPD services.</p> <p>Of the 56 current residents, there are 9 rest home level residents and 3 hospital level residents, including the YPD resident, accommodated in two external units at the basement level of the facility. One of the external units is comprised of seven separate units, including one double occupancy unit. At the time of audit there were for eight residents in these units, seven of whom are receiving rest home level care and one who is receiving hospital level of care. The other external unit, 'the cottage', has four rooms with a shared kitchen/lounge room. At the time of audit there were two residents receiving rest home level care and two receiving hospital level of care in the cottage. Manager and CEO interview advised that St Patricks has been working with the hospital level residents to move them into the main rest home facility, however, these residents have chosen to remain in the external accommodation units (refer to 1.2.8.1).</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 the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence of the manager, the ACM is responsible for the day to day operation of the service and is supported by the CEO and RNs.</p> <p>In the absence of the ACM, the manager with the support of RNs, ensures continuity of clinical services.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>St Patricks has a documented and implemented quality and risk management framework that is available to staff to guide service delivery. All policies are current and align with the Health and Disability Sector Standards and reflect accepted good practice guidelines. The manager with the assistance of an external consultant reviews all policies with input from relevant personnel. New and revised policies and practice guidelines are presented to staff at staff meetings. Staff interviews confirmed that they are advised of new and updated policies.</p> <p>The service delivery is monitored through the organisation's reporting systems utilising a number of clinical indicators such as: complaints; incidents and accidents; surveillance of infections; pressure injuries; falls; medication errors and implementation of an internal audit programme.</p> <p>Clinical indicators and quality improvement data is recorded. Quality improvement data provides evidence that data is being collected, collated and discussed at staff meetings.</p> <p>Residents and family are notified of updates through the facility's resident meetings. There are regular</p>

		<p>monthly staff meetings that include: quality; clinical updates; training; internal audit, resident care and health and safety. Staff sign to demonstrate attendance or that they have read the meeting minutes if not present. Meeting minutes evidenced that all aspects of quality improvement, risk management and clinical indicators are discussed. Staff reported that they are kept informed of quality improvements.</p> <p>There is evidence that the annual internal audit programme is implemented as scheduled. Results of internal audits are made available to staff through monthly meetings. Satisfaction surveys for residents and family are completed as part of the internal audit programme and these evidenced satisfaction with services provided and this was confirmed by resident and family interviews.</p> <p>Where required, meeting minutes and internal audits identify the corrective action plans are developed, responsibilities identified; implemented, reviewed and closed out. There is communication with all staff of any subsequent changes to procedures and practice through meetings and staff notices.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety is monitored as part of the annual internal audit programme. Staff interviews confirmed an awareness of health and safety processes and of the need to report hazards, accidents and incidents promptly. The ACM is in the process of handing over health and safety to a newly appointed health and safety representative. Staff receive training in hazard identification and health and safety as component of the annual training programme. There is evidence that hazard identification forms are completed when a hazard is identified and that hazards are addressed and risks minimised. A current hazard register is available that is reviewed and updated annually or when a new hazard is identified. The hazard register and new hazards are also reviewed and discussed at the three-monthly health and safety meetings.</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 manager is aware of situations that require St Patricks to report and notify statutory authorities, including unexpected deaths, police involvement, sentinel events, infectious disease outbreaks and changes in key management roles. There have been no events requiring essential notifications to external agencies since the last audit.</p> <p>There is an implemented accident and incident reporting process that requires all incidents to be reported in a 'no blame' environment. Incident reporting forms are available throughout the facility. Staff interviews and review of documentation evidenced that staff document adverse, unplanned or untoward events on an accident and incident form which is signed off by the manager. Incident reports selected for review evidenced the resident's family had been notified, an assessment had been conducted and observations completed. There was evidence of a corresponding note in the</p>

		<p>resident progress notes, inclusive of confirmation of notification of the resident's nominated next of kin where appropriate.</p> <p>Corrective actions arising from incidents were implemented. An RN reviews data monthly and specific learnings and results from accidents/incidents inform quality improvement processes and are shared and discussed at monthly staff meetings.</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>	FA	<p>Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position is documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; a signed employment agreement; position specific job description; identification verification and police vetting.</p> <p>Professional qualifications are validated and there are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff and contracted health professionals that require them.</p> <p>An orientation/induction programme is available that covers the essential components of the services provided. Care staff confirmed their role in supporting and buddying new staff.</p> <p>Staff are required to attain role specific competency such as: personal care; hand washing; moving and handling; and medication. There are systems and processes in place to ensure that all staff complete their required mandatory training modules and ongoing competencies. Education session attendance records evidenced that a minimum of eight hours ongoing staff training is provided per annum. This includes training at each monthly staff meeting. The manager and ACM have completed interRAI assessment training and competencies. The remaining six RNs have yet to undertake interRAI training.</p> <p>An appraisal schedule is in place and all staff files reviewed evidenced a current performance appraisal.</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>	PA Moderate	<p>The human resource rationale provides the foundation for workforce planning. Staffing ratios are based on service provider levels and skill mix required, in order to provide safe service delivery. In addition to rostered clinical hours, RNs are allocated additional hours to complete administrative work and training related to their roles.</p> <p>A review of staffing lists and rosters demonstrated that there were 32 permanent staff employed, including management, RNs, care staff, activities staff and household staff. In addition to the</p>

		<p>permanent staff there are 16 staff employed on a casual basis to supplement staffing rosters.</p> <p>In addition to the manager and ACM, there are four permanent and two casual RNs who regularly supplement rosters. Four of the six RN's are newly appointed or at a new graduate level. Supervision and mentoring is provided to the RNs by the manager and ACM. There are agency staff who can be called to provide additional shifts if required. The manager and/or ACM will do extra shifts to provide coverage and supervision if required.</p> <p>Interview and a sample of rosters reviewed demonstrated that the manager and ACM are on duty during the day Monday through to Friday inclusive and available on-call after hours. In addition, there is one RN on duty each morning, afternoon and night shift seven days per week. Health care assistants (HCA) are rostered on each shift to support RNs.</p> <p>Residents are encouraged to be as independent as possible and to engage in rest home daily activities. Residents and families confirmed that their needs were met in a timely manner. Staff interviewed stated that they had sufficient time in order to complete their tasks.</p> <p>The auditors observed that access to the external units on the level below the main facility, where 12 residents including 3 hospital level residents were residing, required staff to leave the main facility (via a lift or stairs) at the basement level and cross the carport to access the external units. Staff are not allocated specifically to the external areas other than answering bells. There is no documented staff rationale process to specifically address the external units staffing and current processes do not provide assurance of RN oversight in the main facility when the RN is attending to residents in external units.</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>There are policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff interviews confirmed an awareness of obligations and procedures for maintaining confidentiality of resident information.</p> <p>All resident information is maintained in a separate uniquely identifiable record and this includes information obtained on admission, with input from the resident and/or resident's family where applicable.</p> <p>Resident care and support information can be accessed in a timely manner and when not in use is protected from unauthorised access by being locked in a cabinet in a staff office. Archived records are securely stored and easily retrievable. Documentation containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public.</p> <p>The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. Medication charts are kept separate from</p>

		<p>residents' files and are accessible by authorised personnel only.</p> <p>Resident records are maintained in hardcopy and information, including progress notes, is dated, signed legible, and entered into the resident record in an accurate and timely manner, identifying the name and designation of the person making the entry. The detail of the progress notes does not meet best practice or documentation guidelines (refer to 1.3.3.4).</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Entry processes into the service are recorded and implemented. Residents' needs assessments are completed for rest home and hospital level of care.</p> <p>Information packs are available for residents and their family and contains relevant information on services at the facility. The admission agreement defines the scope of the service and includes contractual requirements. The residents' admission agreements did not consistently evidence resident and/or family sign-off (refer to 1.1.9.1).</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Resident exit, discharge or transfer is managed in a planned and coordinated manner. There is evidence of communication between services, the resident and the family, as identified in the medical notes. At the time of transition, appropriate information is supplied to the service or individual responsible for the ongoing management of the resident. Referrals were evidenced in the residents' clinical files.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication areas evidence appropriate and secure medicine dispensing systems, free from heat, moisture and light. Medicines are stored in original dispensed packs. Dialysis fluids are stored in carton boxes in a cool, dry place in a basement. The area is locked and not open to access from anyone but authorised staff. The drug registers are consistently maintained with RNs completing weekly checks. Six monthly physical stocktakes are undertaken by the pharmacy.</p> <p>The medication fridge temperatures are monitored and recorded. Staff authorised to administer medicines have current competencies. Administration records and specimen signatures are maintained. Standing orders are no longer used and respite residents' medicines are managed through the same system as long term resident's medicines.</p> <p>Staff education in medicine management is provided. Electronic medicine charts evidenced current residents' photo identification. As required (PRN) medication is identified for individual residents and prescribed in line with legislation, guidelines and good practice. Three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GPs. The residents' medicine</p>

		<p>charts record all residents' medication. At the time of the audit there were no residents who self-administered medicine at the facility.</p> <p>A medicines round was observed and seen to meet current legislative requirements and safe practice guidelines. The RN followed appropriate processes during this medicines round.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Moderate</p>	<p>Registered nurses complete nutritional assessments on admission. Personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet residents' nutritional needs, was sighted.</p> <p>Residents' files demonstrated monthly monitoring of individual resident's weight. Interviews with residents stated their satisfaction with the food service. Residents' individual preferences are met and adequate food and fluids are provided (refer to 1.3.3.3).</p> <p>All aspects of food procurement, production, preparation, transportation, delivery, and disposal comply with current legislation, and guidelines. However the storage of food of fridge and freezers was not consistently in line with best practice.</p> <p>The kitchen staff have all attended food safety training. The provider has an up to date food template control plan awaiting approval.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service has a process in place to inform residents and family of the reasons why services had been declined, should this occur. Referral agencies are informed of the reasons for decline of entry. Resident and/or their family is referred to more appropriate services in the area, when access to the service is declined. Decline of entry only occurs if the residents' needs are not within the scope of the service or if a bed was not available. The manager confirmed that no resident has been declined entry since the previous audit.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Moderate</p>	<p>The service has processes in place to seek information from a range of sources, for example: the resident; family; GP; specialist and the referrer. Residents' clinical files showed evidence of an initial nursing assessment on which the initial care plan was based. However, not all residents' needs were identified in initial assessments.</p> <p>The assessments are conducted in a safe and appropriate environment, usually the resident's room, including visits from the GP.</p>

		<p>The interRAI assessment is not consistently completed in a timely manner (refer to 1.3.3.3). InterRAI assessments reviewed did not show that the use of the interRAI tool triggered the need for additional care requirements of the residents.</p> <p>The residents' files evidenced discharge and/or transfer information from the DHB where required, however, not all residents had NASC assessments on file which reflected their current level of care. The service has appropriate resources and equipment.</p> <p>Interviews with residents and families confirmed their satisfaction with the care provided.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Long-term care plans are in place for residents (refer to 1.3.3.3). Review of the LTCPs showed residents and/or their families sign the LTCPs in evidence of their input into care planning. However, InterRAI assessments are not always used to inform the LTCPs and LTCPs do not always reflect the needs of residents.</p> <p>Short-term care plans are not consistently developed for the management of short-term problems.</p> <p>Resident clinical files showed that the GP review residents according to the level of their needs. Residents' files reviewed using tracer methodology showed that where the residents' condition changed, the GP reviewed their medical care more than weekly and according to their needs. This was confirmed in the medical notes and interview with the GP.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Care plans include interventions. However, interventions are not updated when a resident's condition changes. Where short-term care plans were in place, the interventions did not consistently contribute to meeting the residents' assessed needs and desired outcomes.</p> <p>There is evidence of wound care products available at the facility. The review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were recorded and measurements taken where this was required. Where wounds required additional specialist input, this was initiated. The staff interviews confirmed they have access to the supplies and products they require to meet the needs of the residents. Monthly observations such as weight and blood pressure are completed and are up to date.</p> <p>Residents and family members who were able to be interviewed, expressed satisfaction with the care provided.</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>Interviews with the activities coordinator (AC) confirmed the activities programmes meet the needs of the residents. The AC plans, records, implements and evaluates the activities programmes.</p> <p>The service has one activities programme with indications of when there are specific activities for YPD. Regular exercises and outings are provided for those residents able to participate. The activity programmes include input from external agencies and supports ordinary unplanned/spontaneous activities, including festive occasions and celebrations. There are individualised activities care plans in residents' file (refer to 1.3.8.2). The residents' activities attendance records are maintained.</p> <p>Residents' meeting minutes evidenced residents' involvement and consultation of the planned activities programme. The AC is in the process of completing their qualifications as a diversional therapist.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>Evaluations are carried out by the RNs. Long-term care plans are reviewed six monthly and signed by the family member and/or resident as evidence of participation in care planning. Wound care plans evidenced timely evaluations and review. Interviews verified residents and family are informed of changes in care plans. Residents and families interviewed confirmed their participation in care plan evaluations. The GP interview confirmed the staff inform them when a resident's condition requires review (refer to 1.3.4.2).</p> <p>Activity plans are not always reviewed at six monthly intervals or when the resident experiences a change in condition. LTCPs and STCPs are not consistently updated when a resident's condition changes. Care plans are not always signed and dated when reviews were undertaken. Not all evaluations document progress towards meeting the desired outcome. Evaluations of STCPs do not include sufficient information to inform resident's care.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>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>The service has processes in place to provide choices to residents when accessing, or when being referred to, other health and/or disability services. Communication with families are recorded in incident/accident records and confirmed during interviews.</p>
<p>Standard 1.4.1: Management Of</p>	<p>FA</p>	<p>Documented policies and procedures for the management of waste and hazardous substances are in</p>

<p>Waste And Hazardous Substances</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>place. Policies and procedures specify safety requirements that comply with legislation, including the requirements for clear labelling, disposal and collection of waste. The hazard register is available and current.</p> <p>Current material safety data posters are available and accessible to staff in relevant places in the facility.</p> <p>Staff receive training and education in safe and appropriate handling of waste and hazardous substances (refer to 1.4.6.3).</p> <p>Interviews and observations confirmed that there is sufficient personal protective clothing and equipment provided, such as aprons, gloves and masks that is appropriate to the recognised risks. Protective clothing and equipment were observed to be used in high-risk areas.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is displayed in the entrance to the facility. Buildings, plant, and equipment comply with legislation.</p> <p>There is an implemented preventative and reactive maintenance schedule. Staff are required to identify maintenance issues in a maintenance book and senior staff will refer these to the maintenance person. Staff and maintenance interviews confirmed that staff are aware of the processes for maintenance requests to ensure timely repairs are conducted.</p> <p>Staff interviews and visual inspection confirmed there is adequate equipment to support care, including care for residents with disabilities. The facility has an up-to-date annual test and tag programme. Checking calibration of biomedical equipment sighted is current. The facility van used for residents' outings has a current registration and warrant of fitness.</p> <p>There are quiet areas throughout the facility for residents to use when required. There are paved areas; landscaped lawns, and areas with shade that can be accessed freely by residents and their visitors. Residents stated in interviews they can move freely around the facility and that the accommodation meets their needs.</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</p>	FA	<p>There are sufficient numbers of accessible toilets and showering facilities of appropriate design to meet resident needs located in each area of the facility. Communal toilets have a system to indicate vacancy and have sufficient disability access. Some rooms have their own ensuite. A visitor toilet is located near communal areas.</p> <p>All shower and toilet facilities have call bells; sufficient room; approved handrails; and other equipment to facilitate ease of mobility and independence. Residents were observed being supported</p>

<p>hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>to access communal showers in a manner that was respectful and preserved resident dignity.</p> <p>Hot water temperatures are monitored monthly and were noted to be maintained within recommended temperature ranges. Interviews with the maintenance person confirmed that there were systems in place to ensure that hot water temperatures did not exceed recommended ranges. When temperatures varied from the recommend range corrective actions were taken immediately to address this.</p>
<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>	<p>FA</p>	<p>Most residents have their own room and there are six double rooms for residents who choose to share. There were five of these rooms occupied by two residents, one of which was in the basement level external units. Where residents shared a double room cares where required were provided in private in the absence of the second resident. Communal toilet and shower facilities were separate from bedrooms. All rooms are of sufficient size to allow residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. Resident interviews and observation confirmed that there was sufficient space to accommodate furniture; equipment; and staff as required.</p> <p>Residents and their families can personalise their rooms. Residents' rooms viewed were personalised with their own furniture; possessions and memorabilia.</p> <p>There are designated areas to store equipment such as wheel chairs and walking frames safely and tidily.</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>	<p>FA</p>	<p>The facility has one large main dining room. There is a main lounge area adjacent to the dining room area which is used for activities. There are smaller lounge areas in each of the two main wings with seating and a view of gardens and surrounding district. There is a shared lounge area in the cottage. In addition, there are external areas with seating and shade. All areas can be easily accessed by residents and staff. There are sufficient quiet areas for residents and their visitors to access if they wish, this includes places where young people with disabilities can find privacy.</p> <p>Residents were observed to have their meals with other residents in communal dining room and could choose to have their meals in their room if they so wish or if required.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe</p>	<p>PA Low</p>	<p>Laundry is undertaken on site. This includes laundering of residents' labelled personal clothing. There are laundry staff on duty each day of the week. There are documented procedures to guide staff in the provision of clean and hygienic laundry services, including contaminated/infectious linen. There are two commercial washing machines for facility laundry and a separate one for resident's personal</p>

<p>and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>clothing. There are processes in place for the daily: collection; laundering; repair; and delivery of linen and residents' personal clothing. However, there is no signage for clean and dirty areas for laundry.</p> <p>There are two cleaning staff on duty each week day, one of whom assists with maintenance. Cleaning duties and procedures are clearly documented, to ensure correct cleaning processes occur. In addition to daily and weekly cleaning duty procedures, the facility undergoes a deep clean once a year. There is also a weekly carpet cleaning schedule to ensure that carpet throughout the facility were regularly cleaned.</p> <p>Cleaning products are used according to the cleaning procedure. The cleaners store chemicals on a trolley when cleaning and were observed to keep the trolley with them at all times. However, chemicals not securely stored in all areas of the facility.</p> <p>Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities are available throughout the facility with alcohol gels in various locations.</p> <p>The effectiveness of cleaning and laundry processes are monitored through the internal audit process with no significant problems identified. Resident interviews and observation noted the facility to be clean and tidy.</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>Staff files and training records demonstrated that orientation and the annual training programme includes emergency and disaster procedures and fire safety. An approved fire evacuation plan was sighted. Staff interviews and documentation confirmed that fire drills are conducted at least six monthly. There is a monitored fire alarm, a sprinkler system for firefighting and signage displayed. There is a nominated fire warden for each shift.</p> <p>All RNs have current first aid certificates, ensuring that there is at least one person on each shift with a current first aid certificate.</p> <p>There are sufficient supplies to sustain staff and residents in an emergency situation including alternative energy and utility sources that are available in the event of the main supplies failing. These include access to a barbeque; lighting; an onsite emergency generator; and sufficient food, water, and continence supplies. The service's emergency plan includes considerations of all levels of resident need including YPD.</p> <p>There are call bells to summon assistance in all resident rooms; toilets and communal areas. Call bells are checked monthly by the maintenance person. Observation on the days of the audit and resident and family interviews confirmed that call bells are answered promptly.</p> <p>There are security systems in place to ensure the protection and safety of residents, visitors and staff. These include visitors signing in and out of the building; security cameras throughout the communal</p>

		<p>areas of facility and at key points externally; night time security lighting in place; the facility being locked; and an evening resident and building security check.</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 that is maintained at a safe and comfortable temperature.</p>	FA	<p>All resident rooms and communal areas accessed by residents have safe ventilation and enough external windows providing natural light. The facility is heated by underfloor heating and ducted central heating. Heat pumps are used for cooling in the summer. The environment in all areas was noted to be maintained at a satisfactory temperature.</p> <p>There are systems in place to obtain feedback on the comfort and temperature of the environment and resident and family interviews confirmed that their environment was maintained at a comfortable temperature and there were no issues identified with the temperature of the facility.</p> <p>There is one resident in the facility who smokes. An external covered carport area is the designated as the smoking area to ensure that smoking does not impact on other residents or staff.</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>	FA	<p>The infection prevention and control policies and procedures manual provides information and resources to inform staff on infection prevention and control processes. The responsibility for infection control is clearly defined in the infection prevention and control policy that includes the responsibilities of the organisations' infection control committee, consisting of the infection control nurse (ICN) and representatives from other disciplines in the service. There is a signed ICN job description outlining responsibilities for this role. The ICN is also the ACM who is supported in the role by the facility manager and RNs.</p> <p>The internal audit programme includes infection control audits to monitor the implementation of the infection control programme. The programme is clearly defined and reviewed annually.</p> <p>Strategies are in place to prevent exposure of infections to residents, visitors and staff. Observations during the on-site audit confirmed implementation of infection prevention and control procedures, such as hand washing and the use of anti-bacterial hand gels.</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</p>	FA	<p>The ICN has access to relevant and current information, appropriate to the size and complexity of this service. Infection control is an agenda item at the facility's meetings. Interview with the ICN confirmed they have access to the infection prevention and control nurse specialist at the DHB.</p>

programme and meet the needs of the organisation.		
<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 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>	FA	<p>Policies are developed and reviewed regularly in consultation and with input from relevant specialists at the DHB. The infection control manual is up to date, policies reflect current accepted good practice and reflects relevant legislative requirements. The infection control manual is accessible to staff.</p> <p>The infection control manual consists of a suite of policies and procedures providing specific guidelines for the management of a variety of possible scenarios, including for example, antibiotic use, wound management, blood and body-fluid spills, cleaning, laundry, standard precautions and outbreaks. The policies are appropriate to the facility's size and service requirements. The infection control programme forms part of the facility's quality and risk programme.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Infection control education for staff occurs at orientation and induction of new staff. Ongoing training is provided through the facility's annual education and training programme. The ICN is responsible for the training of staff in the facility. The ICN completes training in infection prevention and control through updates at the DHB and e-learning.</p> <p>Resident education occurs as part of the daily care and encouragement of residents to wash their hands and use hand gels when appropriate. The service includes annual infection control training for residents as part of a resident meetings.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The ICN is responsible for the surveillance programme. Infection control surveillance occurs monthly with analysis of data and reporting at staff and quality meetings. The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infections. The ICN completes infection logs for all episodes of infections. Interviews with staff reported they are made aware of infections through handover and verbal feedback from RNs and the ICN (refer to 1.3.3.3; 1.3.3.4; 1.3.4.2; 1.3.5.2; 1.3.6.1 1.3.8.2). There have been no outbreaks since the previous audit.</p>
Standard 2.1.1: Restraint	FA	St Patricks Home and Hospital's restraint minimisation and safe practice handbook and policies

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>comply with legislative requirements. The restraint policy includes clear definitions of restraint and enablers. Enablers are described in accordance with the Health and Disability Services Standards requirements.</p> <p>Oversight of restraint use at facility is the responsibility of restraint coordinator who is also the ACM. The responsibilities for this role are defined in the position description, sighted. The restraint coordinator has completed training in restraint minimisation and restraint management relevant to their role and was able communicate their knowledge relating to the restraint minimisation standard.</p> <p>Although there were no restraints of individual residents the service is using environmental restraint by keeping the front gate locked for the safety of residents. There is evidence that consent has been obtained, as part of the general consent on admission, for the use of a closed gate. The access number is clearly displayed for those able to read and physically open the gate. There are processes in place to guide service provision around this restraint which are identified in policy.</p> <p>Restraint of residents is considered as a last resort. Enablers are voluntary and the least restrictive option is being used to maintain resident independence and safety. The restraint and enabler register is maintained and current. There was one enabler in use and no individual residents using restraints. The enabler in the form of a bedrail was requested by the resident, use was voluntary and the least restrictive option was implemented. Review of resident records of the one resident using an enabler showed appropriate management of the enabler, meeting requirements as set out in the standards and in their contractual agreement with the DHB.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	The admission agreement is discussed with the resident and family on or prior to admission. The agreement sighted that was to be signed by the resident of their family member, is only available in English. Interview with the manager advised that for those residents and/or families unable to read English, the manager will verbally translate the agreement for the resident and family. Interview with the manager advised that many families took the admission agreement away to consider and review and these were not always signed and returned to the facility. There was no evidence to confirm that non English speaking residents and their families fully understood the content of the agreement and what they had signed agreement to.	i) Admission agreements are not available in languages that could be understood by the resident or their family. ii) Not all admission agreements were signed within the required	i) Ensure that admission agreements are available in a language understood by the resident. ii) Ensure admission agreements are signed by the resident or their nominated representative within the

			timeframes.	required timeframes.
				60 days
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA</p> <p>Moderate</p>	<p>There is one RN on duty at all times, with occasions where RN numbers overlap (e.g. when RNs undertake additional hours to complete administrative work and when the ACM and manager are on duty on the week day morning shifts). Of the six RNs, two RN have been employed by the facility for just over one year and four are either new graduates or have been employed within the preceding year. Mentoring and support is provided to the less experienced nurses by the manager and the ACM, however gaps in knowledge and skill were observed in nursing documentation and in the nursing care residents receive (refer to 1.3.3.3; 1.3.4.2; 1.3.5.2; 1.3.6.1; 1.3.8.2).</p> <p>There are seven HCAs on the morning shift, four on the afternoon shift and two on the night shift. However, none of these staff (RNs or HCAs) have been allocated to provide oversight of the residents in the external units or are stationed in the external units, except for answering call bells. At the time of audit there were three residents residing in the external units assessed as requiring hospital level of care. One of whom, is under a YPD contract and one requiring overnight procedures. There had previously been five hospital level residents in these units and two had been moved. Interviews with the manager stated that St Patricks had sought to move the remaining three residents into the main facility for closer oversight, however, the residents preferred their independence and had refused to move from the units into the main facility. The manager advised that the DHB was aware of this.</p> <p>During the morning shifts observed on audit, most residents from these units had joined the residents in the main building for activities and meals during the day. Registered nurses and HCAs attended those remaining in their rooms. However, in the afternoon and overnight, access to RNs is limited, due to the layout of the facility The external units do not currently include a nurses' station and RNs must leave the main facility to attend to residents in these units, leaving 34 hospital level care residents in the main facility without easy access to an RN.</p> <p>The facility had sought to manage the risk that these residents would not receive the oversight and hospital level care they may require in a timely manner, by implementing a detailed log of events for each hospital level resident in the external units that included identifying any changes in condition and requirements. There was a process whereby residents in the external units were checked on an hourly basis. There was</p>	<p>i) The documented staffing rationale (skill mix policy and rosters) do not reference the processes and requirements for safe staffing relating to the layout of the facility and the external units.</p> <p>ii) Current RN oversight does not assure the required skill mix and experience or access is in place to provide safe care in a timely manner for all</p>	<p>i) Ensure policy, guidelines and rosters reflect the additional need for oversight and service delivery in association with the layout of the facility for all residents, including the external units.</p> <p>ii) Ensure sufficient and accessible aged care experience RN oversight is in place with the required skill mix and experience to provide safe care for all residents, in a timely</p>

		evidence on sign off sheets that the hourly checks had occurred as stated. However, this process had not been documented in the staff rationale process. The process did not provide assurance that hospital level residents in the main facility would receive the level of RN oversight and hospital level care required when the RN left the main facility to attend to residents in the external units.	residents.	manner. 60 days
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Moderate</p>	<p>All aspects of food procurement, production, preparation, transportation, delivery, and disposal comply with current legislation, and guidelines. However the storage of food in fridge and freezers do not consistently meet best practice. Fridge temperatures are monitored three times per week and food temperatures are monitored twice a day.</p> <p>Nutritional assessments are completed on admission. There is limited evidence of nutritional reviews at the six-monthly reviews of resident LTCPs. The LTCP for one of the residents reviewed through tracer methodology showed an entry requiring the resident need for a special diet, however there was no evidence of the specialised diet in place. The nutritional review therefore do not reflect the residents' changed needs. The need for special diets is not always relayed to the kitchen. There is also no evidence of a dietitian having seen the residents with special dietary needs.</p>	<p>i) Fridge and freezer temperatures are recorded three times per week and this practice does not ensure safe and appropriate storage of food.</p> <p>ii) Not all residents receive food in alignment with their nutritional requirements to meet specific medical conditions, and changes to dietary needs are not always implemented.</p>	<p>i) Fridge and freezer temperatures to be monitored at least daily to ensure safe and appropriate storage of food.</p> <p>ii) Ensure the kitchen is informed of dietary requirements to ensure all residents receive food in alignment with their nutritional needs and medical conditions.</p> <p>30 days</p>

<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>The initial medical assessment is completed by a GP in the required timeframe. Ten resident files (four in the rest home and six in the hospital) were reviewed, with the sample size increased by two, in order to include more residents with changed needs. Two of the three residents reviewed through tracer methodology did not have the InterRAI assessments completed. There was no evidence of a re-assessment using the interRAI assessment tool for one tracer resident. Three residents did not have evidence of the interRAI assessments being completed in a timely manner. Review of resident files showed three of ten residents did not have evidence of the interRAI assessments being completed when their needs changed. Three of ten resident files reviewed evidenced residents did not have a LTCP in place based on the interRAI assessment within three weeks of admission.</p>	<p>i) InterRAI assessments are not consistently completed within the required timeframes.</p> <p>ii) Long-term care plans are not always completed within three weeks of admission.</p>	<p>i) Ensure InterRAI assessments are completed within the required timeframes.</p> <p>ii) Ensure LTCPs are completed within three weeks of admission.</p> <p>30 days</p>
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Moderate</p>	<p>Policies and protocols are in place to guide continuity of service delivery. Detailed handovers occur at the end/beginning of each shift.</p> <p>During the review of 10 residents' clinical files, it was found that although progress notes were completed by the HCAs there was little evidence of RN oversight and/or input into the notes. Progress notes were not completed on a daily basis and were insufficient to inform care needs of the resident and did not reflect the concerns, changes in care, treatment, interventions or planning for residents and therefore did not provide continuity of care.</p>	<p>Progress notes are insufficient to inform the resident's care needs and do not completed in line with relevant guidelines and best practice.</p>	<p>Progress notes to be in sufficient detail to inform resident care needs and completed in line with relevant guidelines and best practice.</p> <p>90 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>	<p>PA Moderate</p>	<p>Initial assessments are completed on admission, however two of ten files reviewed had no evidence of an assessment completed. The hospital level (geriatric) resident reviewed through tracer methodology had no evidence of their skin integrity having been assessed as part of the initial assessment and a blister was discovered two days later. The records showed one of the three residents included in tracer methodology, did not have a pain assessment completed during their assessment on admission.</p> <p>Residents files reviewed using tracer methodology evidenced acuity of the residents' changed needs was mainly reflected in the medical notes, laboratory results and specialists reports. Changes experienced by these residents included significant decline in their mental and cognitive status, multiple levels of physical decline and developing medical conditions which altered their physical abilities, including the ability to mobilise, communicate, and their cognition and life expectancy. However, there is little evidence that nursing assessments including interRAI reflected these changes.</p> <p>During clinical review of the healthcare records of four rest home residents, three residents' notes recorded these residents' needs had changed significantly since their admission to the facility. There was no evidence that these three residents were re-assessed by NASC. A referral to the NASC for one of the residents was noted in the resident's file. There is no evidence that the nursing team implemented/activated this referral; nursing notes do not include evidence that the NASC team has been contacted, or that there has been correspondence between the services to facilitate re-assessment for the resident.</p> <p>Following changes in condition, the new goals of two of three residents reviewed using tracer methodology were not identified during goal setting.</p>	<p>i) Not all residents' needs are identified in the initial assessment.</p> <p>ii) InterRAI assessments do not consistently trigger the additional care needs of residents.</p> <p>iii) When the condition of a resident changes, the NASC team is not consistently informed to review the level of care.</p> <p>iv) Residents' nursing care needs are not consistently identified during goal setting.</p>	<p>i) Ensure residents' needs are identified in the initial assessment.</p> <p>ii) Ensure InterRAI assessments trigger the additional care needs of residents.</p> <p>iii) Ensure when the condition of a resident changes, the NASC team is informed to review the level of care.</p> <p>iv) Ensure residents' nursing care needs are consistently identified during goal setting.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery</p>	<p>PA Moderate</p>	<p>Long-term care plans are developed and evidence resident and/or family participation.</p> <p>The hospital level (geriatric) resident reviewed using tracer methodology had a LTCP</p>	<p>i) Long-term care plans</p>	<p>i) Ensure long-term</p>

<p>plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>completed prior to completion of an interRAI assessment.</p> <p>The resident files reviewed using tracer methodology evidenced STCPs were not always in place for the management of acute problems. The rest home level tracer resident did not have an STCP initiated related to discovery of liaisons, decline in condition or pain management. The hospital level (geriatric) tracer resident did not have an STCP in place for the pressure injury initially determined to be stage one and three days later assessed as stage three.</p> <p>All residents' long-term care plans were in place however service delivery planning was completed with insufficient detail to inform all care needs of residents.</p>	<p>are not always based on interRAI assessments or reflect the needs of residents.</p> <p>ii) Short-term care plans are not always completed for management of acute problems.</p>	<p>care plans are based on interRAI assessments and reflect the needs of residents.</p> <p>ii) Ensure short-term care plans are completed for management of acute problems.</p> <p>90 days</p>
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Residents' LTCPs evidenced interventions are recorded. However, 3 of 10 resident file reviews showed that the interventions remain the same even when the residents' condition changed. Not all care plans are individualised. None of the three residents reviewed through the tracer methodology process had short-term care plans for acute problems in place other than wound care plans (refer to 1.3.5.2 and 1.3.8.2). The only short-term care plans used by the service were wound care plans and interventions did not always support the achievement of residents' goals. Interview with staff confirmed they were not aware of the requirement for short-term care plans for all acute problems.</p>	<p>i) When a resident's condition changes, interventions recorded in the LTCPs did not always reflect the changed needs.</p> <p>ii) Interventions recorded in STCPs did not always support the achievement of the</p>	<p>i) Ensure when a resident's condition changes, interventions recorded in the LTCPs reflect the changed needs.</p> <p>ii) Ensure interventions recorded in STCPs support the achievement of the resident's</p>

			resident's goals.	goals. 90 days
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Moderate</p>	<p>Six monthly LTCP evaluations occur. Evaluations do not all document progress towards meeting the desired outcome. When a resident's condition changes, the LTCP is not evaluated to accurately reflect the residents' needs. Three of the residents files reviewed for six-monthly re-assessment of LTCPs did not show evidence of timely review. The tenth resident file was that of a resident that was new to the facility and did not yet require review of the LTCP. Three of three residents reviewed using tracer methodology evidenced the LTCP was not reviewed when their condition changed. When in place, STCPs do not consistently reflect changes due to a change in condition of a resident. For example three of three residents reviewed through tracer methodology did not have care plans for short term issues and where wound care plans were in place the wound care plans (STCP) did not always reflect the wound care needs of the residents (ie. goals are not consistently recorded, interventions do not align with desired outcomes).</p> <p>The hospital level (medical) resident's file reviewed using tracer methodology had evidence of additional activities added to the LTCP under the activities plan section, however, the entries were not dated or signed. Files reviewed with STCP showed the signature of the person completing the review or date completed was not consistently recorded.</p> <p>The LTCPs include activity care plans. Activity care plans were developed around the specific interests of residents including the YPD. However, resident activity care plans were not completed and not all activity care plans had not been reviewed at six monthly intervals or when the condition of the resident changed. Although two of the residents files reviewed through tracer methodology had their activity plans reviewed within six months, the review did not occur when the residents' condition changed and therefore did not meet the changed needs of the residents.</p>	<p>i) Evaluations of STCP and LTCP are not consistently completed to reflect the changed needs of residents.</p> <p>ii) Evaluations of STCP and LTCP are not consistently signed or dated when completed.</p> <p>iii) Evaluations of care plans do not consistently document progress towards meeting the desired outcome.</p> <p>iv) Activity plans are not consistently reviewed within the</p>	<p>i) Ensure evaluations of STCP and LTCP are not consistently completed to reflect the changed needs of residents.</p> <p>ii) Ensure evaluations of STCP are signed and dated when completed.</p> <p>iii) Ensure evaluations of care plans document progress towards meeting the desired outcome.</p> <p>iv) Ensure activity plans are reviewed within the required timeframes.</p>

			required timeframes.	90 days
Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.	PA Low	<p>Cleaning and laundry procedures were implemented. Staff were able to describe which were the clean and dirty areas of the laundry and were observed to maintain these. However, these areas were not visually delineated.</p> <p>There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. However, cleaning products stored in the laundry cupboards were not consistently locked when unattended. Cleaning chemicals were noted to be stored above a sink at the top of the stairs to the facility that was accessible to residents entering from outside the facility.</p>	<p>i) Clean and dirty areas of the laundry were not clearly delineated.</p> <p>ii) Cleaning products were stored in areas accessible to residents.</p>	<p>i) Ensure clear delineation of clean and dirty laundry areas.</p> <p>ii) Ensure all chemicals are stored securely.</p> <p>30 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.