# Nazareth Care Charitable Trust - Nazareth House

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Nazareth Care Charitable Trust

**Premises audited:** Nazareth House

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

**Dates of audit:** Start date: 19 March 2019 End date: 19 March 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:** 77

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

## General overview of the audit

Nazareth Community of Care in Christchurch provides rest home and hospital level care for up to 80 residents. The service is operated by the Sisters of Nazareth under Nazareth Care Australasia and is managed by a general manager and a care services manager. Residents and family members were all positive about the high level of care provided and the availability of management to respond to enquiries.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service provider’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

A continuous improvement in relation to the implementation of quality improvement processes was acknowledged. There were no corrective actions raised. Improvements have been made to staff training processes, the wording of the service agreement and to the formulation of residents’ goals, which has addressed those areas identified as requiring improvement at the previous audit.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required and additional resources are provided to residents with any significant sensory loss.

Residents and family members are informed about their right to make a complaint. A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

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

The appointment, orientation and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes annual individual staff performance reviews.

Staffing levels and the skill mix of staff meet the changing needs of residents.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. The care plans are reviewed every six months or earlier if required, with input from the resident/family as appropriate. Files sampled identified integration of allied health and a team approach.

The activities team implements the activity programme to meet the individual needs, preferences and abilities of the residents.

Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency assessment and receive annual education.

Residents' food preferences and dietary requirements are identified on admission. All meals are cooked on-site, taking into consideration any dietary preferences or needs.

## Safe and appropriate environment

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

A chapel has been added to the facility since the last audit. The facility has a current building warrant of fitness, which is inclusive of the chapel. According to the fire service, there is no requirement for a variation to the already approved fire evacuation plan.

## 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 organisation has implemented policies and procedures that support the minimisation of restraint. Six enablers and one restraint were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

|  |  |  |
| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme and associated policies and procedures are reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 18 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 40 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints and compliments policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Copies of the complaints form are at the front entrance of the facility. Feedback of any nature is actively encouraged.The complaints register showed that 23 complaints have been received over the past year. Actions taken through to an agreed resolution are documented and completed within the required timeframes. There is evidence that continuous improvements have been made where possible. Many of the entries in the register were concerns, rather than formal complaints. According to the care services manager, the concerns have been managed as complaints to ensure the underlying issues were reviewed and quality improvement processes implemented to prevent any escalation of the issue(s). Compliments are recorded in a separate register. The care services manager and the general manager share the responsibilities for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they are kept well informed about any changes to their/their relative’s status and are advised in a timely manner about any incidents, accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed and in adverse event reports. Staff understood the principles of open disclosure. Policies and procedures on open disclosure meet the requirements of the Code. The care services manager and the unit managers know how to access interpreter services, although reported this has not been required as all residents to date have been able to speak English. A communication and sensory loss policy includes a section on identifying the needs for an interpreter through assessment of all five senses. Access to local interpreter services and ways of supporting residents’ communication needs are also described, as is the option of accessing advocacy services for further advice if indicated. One person with specific communication needs is receiving additional support to have these addressed.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The Nazareth Community of Care was built to replace the earthquake damaged Nazareth House, which had been established by the Sisters of Nazareth early in the 20th century. It is under the governance of the Nazareth Care Charitable Trust, one of two boards of Nazareth Care Australasia, which was established in 2010. The Trustees of the Nazareth Care Charitable Trust are primarily Sisters of Nazareth. The strategic plan notes the six values of the Sisters of Nazareth: Love, Compassion, Patience, Justice, Respect and Hospitality. A mission statement of the Sisters of Nazareth and of the Nazareth Community of Care described the Christian nature of their ministries of care and education and their openness to respond to the needs of the times. There is also a documented philosophy referred to as ‘The Nazareth Way’, which is said to underpin all services delivered. Strategic principles are outlined and a vision statement noted. Goals and related strategies are listed with intended outcomes integrated into the goals. Three horizons on a growth path more finitely describe the overarching directions of the organisation. Additional documentation showed some objectives and strategies that are specific to Christchurch’s Nazareth Community of Care have been developed. A sample of monthly reports to the Chief Executive Officer in Australia was sighted, as was an annual performance review report for 2018. The reports included information on financial performance; occupancy related data; service, human resource and environmental risks; staff training and extracts from the quality management reports. A general manager, who has been in the role since January 2017, is responsible for management of the Christchurch Nazareth Community of Care. This person has suitable skills and attributes with over 12 years’ experience in the management of aged care facilities in New Zealand. She is a registered nurse (Masters of Health Science) with a current practising certificate, a law degree, a post graduate Diploma in Management and is a qualified auditor. Responsibilities and accountabilities are defined in a position description and an individual employment agreement. The general manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing professional development and attendance at local district health board (DHB) meetings for managers of aged care facilities. The Nazareth Community of Care provides services under the DHB Aged Related Residential Care Agreement. On the day of audit there were 26 rest home level residents and 49 hospital level care. One other resident is under a Ministry of Health Young Persons with a Disability contract (rest home level care) and another is under an Accident Compensation Corporation contract (hospital level care). There were no residents receiving respite care on the day of audit. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | An organisational quality plan 2019 and a separate risk management policy and procedure were sighted. These provide guidance for implementation of a quality and risk system that reflects the principles of continuous quality improvement. Components of these plans and frameworks include management of incidents and complaints, internal and external audit activities, an annual resident and family satisfaction survey, a staff survey, monitoring of identified risks within eight key categories, clinical incidents including infections and pressure areas, restraint use and health and safety. Implementation of the system is supported by an electronic monitoring system called ‘AngelTrend’.Meeting minutes reviewed confirmed there is regular and ongoing review and analysis of quality indicators occurring. Related information is reported and discussed at the monthly quality and risk team meetings and at regular registered nurse, support staff and general staff meetings. Staff reported their involvement in quality and risk management activities through compliance with ongoing requirements and improvements, ensuring they remain updated by reading meeting minutes and by completing relevant forms such as for incidents. Relevant corrective actions are developed and implemented to address any shortfalls. Not only are the shortfalls addressed but where applicable the opportunity is taken to develop wider quality improvement initiatives around them. There is a strong culture of continuous quality improvement within this organisation and a continuous improvement rating has been applied to criterion 1.2.3.7 to acknowledge their commitment to this process. Resident and family satisfaction surveys are completed annually. The most recent survey showed overall satisfaction with some specific feedback about meals and responses to call bells followed up with quality improvement processes, all of which have since been evaluated as being satisfactory.Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Reviews of the policies and procedures are ongoing and examples of this occurring were sighted.The care services manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. This person is familiar with the Health and Safety at Work Act (2015) and works alongside the general manager and a health and safety officer to implement the requirements. The health and safety officer is a personal care worker who has undertaken relevant training.  |
| Standard 1.2.4: Adverse Event Reporting 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.  | FA | Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. They also included evidence of open disclosure occurring. Adverse event data is collated and entered into the AngelTrend database for quality and risk management reporting. It is then analysed and reported to the general manager, who in turn passes it on to the Chief Executive Officer in the monthly report. Results of the analyses, and any corrective actions and/or continuous improvement initiatives, are discussed at the next quality and risk management meeting and at the departmental staff meetings, as relevant. The general manager and the care services manager described essential notification reporting requirements, including for pressure injuries. They advised there have been several notifications of significant events made to the Ministry of Health, examples of which have included call bell failure, theft, pressure injuries, changes in unit managers, an employment dispute and two examples of police involvement. Documentation related to all such events was available and appropriate follow-up evident. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting, interviews and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained. Evidence was viewed to confirm that the registrations of health professionals who are associated with the residents are being checked annually.Staff orientation includes all necessary components relevant to the role. Since the previous audit, the orientation process has been fully reviewed, is comprehensive and covers a range of requirements over a six week timeframe. Staff reported during interviews that the orientation process prepares staff well for their roles and that additional time is provided for people with less previous experience. Records in staff files reviewed included evidence of completed orientation checklists and competencies. A performance review after a three-month period is now occurring. Continuing education is planned on an annual basis, including mandatory training requirements. Mandatory training topics, as required by the Aged Related residential Care Agreement, are delivered annually in seven workshops over approximately two and a half hours. This has addressed the issue raised for corrective action at the certification audit that not all mandatory training topics were included in the education programme. Additional training covers competencies for infection control and restraint, for example. Special interest topics such as diabetes and visiting educators such as wound management are scheduled throughout the year. Staff education sessions are scheduled once or twice each month. Attendance records are maintained and were viewed. Twenty-four of the personal care workers have completed level three and/or four of their national certificate towards a New Zealand Qualification Authority education programme, eleven have completed level two and seven others have recently enrolled. Records reviewed demonstrated completion of annual performance appraisals. There are enough trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. All registered nurses have a current first aid certificate, as do some key caregivers and the wellbeing and lifestyle coordinator.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A staff rationale policy and procedure described the process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents and examples of this occurring were provided and were evident on the roster. An after-hours on-call roster is in place to cover operational, clinical and property related concerns. Staff reported that all of the managers have an open door policy, they are always accessible and that there is good access to advice when needed. Most residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Agency nurses are used when there are no other Nazareth Community of Care staff available to fill a shift. A ‘WAS’ model comparison tool is being used as an acuity tool to ensure each shift covers residents’ service delivery requirements safely. In addition to the care services manager and the general manager being registered nurses, there are also two registered nurse unit managers in the management team. All of the registered nurses have a current first aid certificate, as well as a current medicine competency. There is 24 hour seven days a week (24/7) registered nurse coverage on both the ground and the first floor and in the absence of a unit manager, the registered nurse takes on the leadership role. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The Nazareth Community of Care admission agreement was sighted and has been altered to conform to the requirements of the CDHB ARRC agreement in relation to exclusions from service D14.1 which was the basis of a CAR in the last audit. The requirements of this standard are now met. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | Medication management is implemented using an electronic system and blister packs from a contracted pharmacy. All aspects of medication management are in line with those recommended by the Medicines Care Guide for Residential Aged Care. Medications are delivered to Nazareth Community Care and checked against the prescription and signed by an RN. Input is available from the pharmacist on request.Controlled drugs are stored securely in a double locked cupboard and always checked by two medication competent staff. The controlled drug register showed evidence of weekly and six monthly stocktake with accurate entries. Specimen signatures were sighted and updated six-monthly. Non-packaged medications were stored in a locked cupboard and showed evidence of stock rotation. All medications sighted were within the recommended use by dates. Medication fridge temperatures were recorded and within the recommended range. Storage systems for medicines is in a locked medication room that only those staff who are medication competent can access via a swipe card. Good prescribing practices were noted, including the prescriber’s signature and date recorded on the commencement and discontinuation of medications. The reasons for pro re nata (PRN) medications met the required standard. The requirement for three monthly review by a GP was met and due dates consistently recorded on the medication chart.At the time of audit there were two residents who were self-administering their medications. An assessment was completed by the RN and signed by the GP, this was reviewed every three months. The medications are stored in a locked cupboard in the resident’s room. Records of the resident’s education of the side effects and special instructions were observed. The RN checked and signed each day that medicines had been taken.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The kitchen staff are headed by a catering manager who provides ongoing education to staff. There are three experienced cooks who provide a choice of two meals on the menu. The menu follows a summer/winter pattern and each season has a four week rotation. The menu was reviewed by a qualified dietitian in September 2018 and is in line with recognised nutritional guidelines for older people. A food control plan was in place and current, verified by the city council and is due again in May 2019.All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation. The kitchen was observed to be clean and orderly with evidence shown of stock rotation. Food temperatures, including for high risk items are monitored appropriately and recorded.A nutritional assessment is completed on admission and reviewed six monthly or sooner if indicated. Preferences, allergies, likes and dislikes, special diets for example diabetic, and modified texture requirements are accommodated in the daily meal plan. Specialised cutlery is available and those requiring assistance are given so in a manner that maintains their dignity. A meal time observed during the audit showed that there was sufficient time to eat in an unhurried fashion and that the dining room was uncluttered with space to move freely between the tables. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Generic goals that were the cause of a CAR in the last audit, have been replaced with the identification of specific resident needs and individualised resident centred goals have been formulated. The requirements of the standard are now being met. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observation and interview with the unit manager verified that care provided to the residents was consistent with their needs, goals and plan of care. The interview with the GP confirmed that discussion and referral to allied health professionals took place in a timely manner. When medical input was required, he was notified promptly, and any medical orders were appropriately carried out. Family/whānau expressed during interview that assistance was given according to the wishes of their relatives. An overhead hoisting system is in place in residents’ rooms as well as mobile hoists, pressure relieving mattresses and cushions. Documentation, observation and interview with the unit manager verified that care provided to the residents was consistent with their needs, goals and plan of care. The interview with the GP confirmed that discussion and referral to allied health professionals took place in a timely manner. When medical input was required, he was notified promptly, and any medical orders were appropriately carried out. Family/whānau expressed during interview that assistance was given according to the wishes of their relatives.  |
| Standard 1.3.7: Planned ActivitiesWhere 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. | FA | Two qualified diversional therapists meet monthly to create a varied programme designed to develop and maintain strengths and interests that are meaningful to the residents. A social profile is taken on admission with likes, dislikes, hobbies and interests which are used to inform the individual plan for residents with person centred goals. Activities include exercises, mini golf, pet therapy, outings and making crafts to sell at market days. A new initiative has been the introduction of a sensory stimulation programme that residents commented was very therapeutic. Resident meeting minutes showed positive feedback for the wellbeing and lifestyle programme from residents and family who attended. A main activities room caters for large group activities while smaller lounges cater for small group gatherings and the cinema is used for movie viewing. The resident’s activity needs are evaluated six monthly as part of the formal six monthly care plan review. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents’ needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were sighted for skin tears, chest infections and urinary tract infections. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed expressed their involvement in evaluation of care plans during meetings with staff and completion of a care consultation form which is conducted six monthly. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A chapel, which is used by some of the residents on a daily basis, has been built onto the facility since the last audit. The chapel has two direct external egresses and its automatic fire safety systems were integrated into those of the already constructed Nazareth Community of Care building. According to documentation from the fire service there was no need for any change or variation to the previously approved fire evacuation plan for this facility. The Nazareth Community of Care has a current building warrant of fitness that has an expiry date of 1 October 2019. This warrant is inclusive of the chapel.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities and includes infections of the chest, urinary tract, mouth and skin. The infection control coordinator reviews all reported infections each month. Information is entered into an electronic system and data is graphed, analysed and monitored for trends, possible causative factors and required actions. Results are discussed at quality meetings and shared with staff at shift handover. A log is kept in each resident’s file of their infections.A summary report of a recent gastrointestinal infection outbreak was reviewed and demonstrated that policies and procedures were followed appropriately with notification, extra staffing, isolation and increased education carried out. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Related policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator, with support from the care services manager, provides direction and oversight for enabler and restraint management in the facility. During interviews, staff demonstrated a sound understanding of the organisation’s policies, procedures and practice. According to the restraint register, there was one person using a restraint at the time of audit. This was use of a brief for when they are in a chair. Six residents were listed as using an enabler. These were the least restrictive equipment for the purpose, which is used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, during review of a resident’s file, and from interviews with staff. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |
| --- |
| No data to display |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.7A process to measure achievement against the quality and risk management plan is implemented. | CI | Issues of concern, shortcomings and inadequate or inefficient systems that are identified during quality and risk system monitoring processes are consistently being addressed through the implementation of separate plans for continuous improvement. All continuous improvement initiatives are documented within the electronic system of AngelTrend. Each is entered according to an identification number, area of priority, method, expected outcome as per organisational objectives, person responsible, date of identification and of completion and states whether the interventions were deemed as effective or not. The issue(s) is clearly identified, an action plan is developed using a ‘plan, do study, act’ (PDSA) approach; intended measurable outcomes are noted and there is a description of how the results are to be evaluated. Completed initiatives note what the evaluation has revealed. Records sighted showed this continuous improvement format and the associated processes have been used for a diverse range of topics, varying from issues raised about food, complaints management, service delivery shortfalls, including medicine errors, to internal audit results. Many have been implemented to enhance outcomes even after a corrective action raised at an audit has been closed. A significant example was an initiative regarding ‘intentional rounding’, which was initially commenced due to several residents becoming at high risk of falling. The process was research based, planned and implemented according to the PDSA cycle and was fully evaluated. Positive results were noted in the conclusion and a decision to continue ‘intentional rounding’ indefinitely for vulnerable residents was made. Its use has also reportedly provided reassurance to concerned family members and proven useful for managing residents with changing health status. Throughout the audit, staff, residents and family members reported improvements that have been made at Nazareth Community of Care. They spoke of actions taken towards the improvements and of the managers having an open door policy and being receptive to change. This confirmed that the concept of continuous quality improvement has become an integral part of the operations, or culture, of Nazareth Community of Care that is going beyond the care services manager, who is primarily responsible for implementation of the quality and risk management system. | Multiple continuous quality improvement initiatives have been implemented to address issues, shortcomings, systems or processes that have been identified through quality and risk monitoring processes as having the potential to impact on the quality of residents’ care. This has resulted in a culture of continuous quality improvement becoming embedded within the service. |

End of the report.