

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

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: St Catherine's Rest Home Limited

Premises audited: St Catherine's Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 6 March 2020 End date: 6 March 2020

Proposed changes to current services (if any): Increase the certified bed numbers by one to a total of 15 beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 12

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
Yellow	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
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

St Catherine's Rest Home Limited - St Catherine's Rest Home provides rest home level care for up to 15 residents. St Catherine's is part of the charitable organisation overseen by the Sisters of Mercy Ministries New Zealand Trust Board. The executive manager has worked at St Catherine's for over 21 years and is responsible for the services provided at St Catherine's. There is a management agreement in place between St Catherine's Rest Home and the chief executive officer (CEO) of Mercy Healthcare.

This certification audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, family members, the contracted podiatrist, managers, staff, the CEO of Mercy Healthcare and a member of the pastoral care team. The audit also included verifying that the organisation was sufficiently prepared to increase as planned the certified bed numbers by one, to a total of 15 beds.

Residents and family members interviewed confirmed being very satisfied with the services provided and that all their needs and wants are being met in a timely manner.

There were no improvements required as a result of this 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.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

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

Processes are in place to ensure that residents who identify as Māori will have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

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

There have been no complaints received since the last audit. Staff and the executive manager are aware of their responsibilities, and the required timeframes required in the Code should a complaint be received.

Organisational management

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

The quality and risk system and processes are well integrated in practice and support effective, timely service delivery. The quality management systems includes having current policies and procedures available for staff, a comprehensive internal audit programme, resident / family satisfaction surveys, staff satisfaction surveys, compliments, complaints management, incident / accident and near miss event reporting, hazard identification and management, minimising the use of restraint, and infection surveillance. Quality and risk management activities and results are shared among management, staff, and residents as appropriate. Corrective action planning is well documented.

Recruitment processes align with current accepted practice. Staff are provided with an orientation and ongoing education programme that is relevant to their role. Applicable staff and contractors maintain current annual practising certificates.

The service has a documented rationale for staffing. Staffing numbers, including registered nurse hours, meet contractual requirements. Three nurses, including the executive manager, have current interRAI competency.

Residents' information is kept safe and secure onsite and all entries are legible.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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St Catherine's Rest Home admits residents primarily from the Sisters of Mercy, Sisters from other religious congregations and other retired women who welcome the peaceful and prayerful lifestyle offered by the service. Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

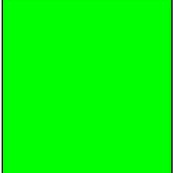
The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and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

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

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

The food service meets the nutritional needs of the residents with special needs catered for. There is an approved food control plan in place.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The service has processes in place to protect residents, visitors and staff from harm as a result of exposure to waste or infectious substance.

There are documented emergency management response processes which were understood and implemented by staff. This included six monthly fire drills.

The building has a current building warrant of fitness and an approved fire evacuation plan. The building renovation programme is nearing completion.

The facilities meet residents' needs and provided furnishings and equipment that are regularly maintained and updated. Bedroom areas allow residents to move around with or without assistance. Each bedroom is single occupancy and has an ensuite bathroom with a toilet, shower and hand washing facilities.

The lounge and dining areas, chapel, prayer room, physiotherapy room and other areas meet residents' relaxation, activity and dining needs. There are external areas where residents and family members can go to for recreation. The outdoor areas provide furnishings and shade for residents' use.

The facility is kept at a suitable temperature. Opening doors and windows creates an air flow to keep the facility cool when required.

Appropriate security is in place, and security cameras were in use monitoring outside the building.

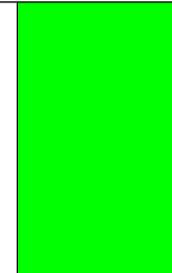
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The restraint minimisation and safe practice policy includes a commitment to using restraints as a last resort. The definition of restraint and enablers aligns with the standards. There were no restraint or enablers in use at the time of the audit. Staff are provided with annual education on restraint minimisation and the use of enablers and have current related competencies.

Infection prevention and control

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



Standards applicable to this service fully attained.

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

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>St Catherine's Rest Home has policies and procedures to meet their obligation in relation to the Code of Health and Disability Services Consumer Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and ongoing training as verified in the training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files sampled showed that informed consent has been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA) or residents and the general practitioner makes a clinically based decision on resuscitation authorisation if required. Staff were observed to gain consent for day to day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.</p>

consent.		
<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>	FA	<p>As part of the admission process, residents and family/whanau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents interviewed were aware of the advocacy service, how to access this and their right to have support persons. The pastoral care team is also available as advocates if required.</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>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family members and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>St Catherine's Rest Home implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with the Code. During interview, residents, the executive manager, and staff verbalised their understanding of the complaints process and this aligned with organisation policy.</p> <p>A suggestions box is attached to the outside of the executive manager's office door. Concerns / complaints forms are readily available to residents and family members.</p> <p>A complaints register is maintained. There have been no complaints received since the last audit including from the District Health Board, Ministry of Health or Health and Disability Commissioner. Residents and family members interviewed confirmed they had no complaints and were very satisfied with the services provided. The residents noted if they had any concerns/complaints they would discuss them with the executive manager.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed</p>	FA	<p>Information about consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception and throughout the facility. The Code is available in te reo Maori and English. Family members and residents interviewed were aware of residents' rights and confirmed that information was provided to them during the admission process.</p>

of their rights.		The information pack outlines the services provided. Resident agreements signed either by the resident or by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence. All residents were assessed as requiring rest home level of care. They are able to move freely into the surrounding areas and in and out of the facility with no restrictions.</p> <p>Records sampled confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>There is an abuse and neglect policy and staff interviewed understood how to report such incidents if suspected or observed. The registered nurse (RN) reported that any allegations of neglect if reported would be taken seriously and immediately followed up. There were no documented incidents of abuse or neglect in the records sampled. Family/whanau and residents interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	The required policies on cultural appropriateness are documented. Policies refer to the Treaty of Waitangi and partnership principles. The Maori Health Plan includes a commitment to the principles of the Treaty of Waitangi and identifies barriers to access. It also recognises the importance of whanau. Interviewed staff reported that cultural needs would be provided in the event of death as outlined in the policy. All staff receive cultural awareness training. There were no residents who identified as Maori at the time of the audit.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services</p>	FA	Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines, as recognised by the family/whanau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents interviewed confirmed they were encouraged to be involved in the development of their long-term care plans. Residents' personal preferences and special needs were included in care plans sampled.

which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and this was confirmed by the residents. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The RN stated that there have been no reported alleged episodes of abuse, neglect or discrimination towards residents.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through ongoing professional development of staff. The RN confirmed they sought prompt and appropriate medical intervention from the general practitioner (GP) when required and follow up on any medical requests. The GP was not available for interview. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Some care staff are enrolled in Careerforce level three or four. The RNs reported that they attend regular conferences and one is studying for a post graduate certificate in health sciences.</p> <p>Policies and procedures were linked to evidence-based practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures.</p> <p>Staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and the use of family members and communication cards is encouraged.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned,</p>	FA	<p>St Catherine's has a documented mission statement, philosophy and values that is focused around the provision of individualised, quality care in a peaceful, loving environment for women of Catholic faith.</p> <p>The executive manager monitors the progress in achieving these goals via a regular formal three-monthly quality and risk review. The day to day operations and ensuring the wellbeing of residents is the responsibility of the executive manager (who is a registered nurse), with the support of three other registered nurses. A</p>

<p>coordinated, and appropriate to the needs of consumers.</p>	<p>formal management service agreement is in place between St Catherine's Rest Home and the chief executive officer (CEO) of Mercy Healthcare Auckland Ltd (Mercy Healthcare). The executive manager reports to the CEO of Mercy Healthcare, and to the McAuley Trust (the owners of the facility) and to the congregational leaders of the Sisters of Mercy (who are responsible for the pastoral care for the residents) formally at least monthly or more frequently where applicable. The comprehensive written reports provided an overview of operational issues as well as quality, risk, staffing/human resources and financial issues. The executive manager and the CEO of Mercy Healthcare offices are co-located on the same floor. The executive manager is responsible for business and strategic planning for St Catherine's Rest Home. This includes wide consultation with the governance and spiritual care stakeholders who are responsible for approving the plan.</p> <p>The Mercy Healthcare CEO reports to a governance board on a regular basis, which in turns reports to an advisory group from the Sisters of Mercy Ministries Trust Board (Tiaki Manatu) which is a charitable trust. Three of the Sisters of Mercy are trustees.</p> <p>The renovation programme underway within the building where St Catherine's rest home is located is nearing completion. Changes included (but are not limited to), replacing carpet, replacing heating/ventilation, and hot water systems, and creating 11 independent living private apartments on level one and two of the building for women of faith. The architect/project manager advised the Code of Compliance documentation is currently with the Auckland City Council for review and is expected to be finalised in the next two weeks. The architect/project manager advised a certificate of public use was not required in relation to the completed renovations.</p> <p>The building has four levels with the entrance, some apartments, the laundry, archive area, hairdressing salon, podiatrist clinic room and storage areas are located on the first floor (ground). On the next level (two) there are more apartments, offices (including the pastoral care team and executive manager), the kitchen and dining area, external courtyards, chapel, physiotherapy room, and prayer room/visitors lounge. The third and fourth levels have 21 bedrooms in total and a lounge/kitchenette area on both floors and are known as St Catherine's (rest home) and St Mary's (convent). There are two elevators that move between all levels – one at each end of the building.</p> <p>St Catherine's Rest Home has a contract with Auckland District Health Board for the provision of aged related residential care at rest home level of care. There were twelve residents receiving care at the time of audit. The executive manager advises all residents have been assessed as requiring rest home level care. The organisation is increasing the number of certified beds by one during this audit. The five sisters currently living in the St Mary's convent live independently; however, are able to participate in the St Catherine's Rest Home activities programme and pastoral care programme, and have their meals provided by the St Catherine's kitchen. Medicine oversight is provided by staff for identified Sisters where required. All 21 bedrooms in St Catherine's and St Mary's are appropriately furnished and could be used for the provision of rest home level care. The executive manager advised the 10 bedrooms on level three are for residents requiring rest home level care, and any five of the 11 beds on level four will also be used for rest home level care if/when required.</p> <p>The executive manager is an experienced registered nurse, who has been in this or another senior</p>
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		<p>management role at St Catherine's since 1998. The executive manager participates in relevant ongoing education as required to meet the provider's contract with ADHB. The executive manager has post graduate qualifications in business health management and economics, maintains a current annual practising certificate (APC), current interRAI competency, and participates in the ADHB aged care steering group meetings and is the chairperson of the local aged related care 'cluster group' meeting. The executive manager is readily available to residents and family and this was observed at audit and noted by residents interviewed.</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>The continuous quality improvement officer / infection prevention and control nurse (an experienced registered nurse) is the designated deputy in the executive manager's absence. There is a documented job description that details the position roles and responsibilities and exclusions. Attending external meetings and all financial matters become the responsibility of the Mercy Healthcare CEO. The executive manager advised the arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>St Catherine's Rest Home has a mature quality and risk management system which is understood and implemented by staff. The programme is facilitated by the continuous quality improvement officer/infection control nurse (CQI/ICN) who has one day a week designated to undertake these activities and works two other shifts a week as a registered nurse.</p> <p>The quality and risk programme includes internal audits, resident and staff satisfaction surveys, incident, accident and near miss event reporting, health and safety reporting, hazard management, infection surveillance data collection and management, restraint minimisation, monitoring the use of enablers, compliments, and complaints management.</p> <p>Policies and procedures were readily available for staff. Policies have been reviewed in a planned manner (every two years), by the executive manager and delegated staff. The executive manager is responsible for approving any changes prior to release and for document control processes. A paper copy of all policies is in the nursing station.</p> <p>A comprehensive internal audit programme is implemented. The results of internal audits sampled demonstrated a high level of compliance with organisation policy. An annual review is undertaken of the previous year's quality and risk programme and outcomes (for the period ending 31 March 2019) and this document was sighted. The CQI/ICN maintains a quality improvement register. Since 1st October 2019, 27 improvements have been documented. If an issue or deficit is found, a corrective action is put in place to</p>

		<p>address the situation. Corrective actions are developed and implemented and monitored for effectiveness.</p> <p>Actual and potential risks are identified using the quality and risk planning processes. The electronic organisation risk register is extensive and showed regular monitoring (at least three monthly) of the organisation's risks. Colour coding is used to 'traffic light' risk for quick reference. Information is communicated to the Mercy Healthcare CEO and the Board and the other services that receive the executive manager's monthly reports. Residents' clinical risk is monitored via interRAI and other clinical assessments.</p> <p>New hazards are discussed, monitored and managed via the health and safety (H&S) committee, and discussed at other relevant meetings. A staff member and the executive manager have attended external H&S training in 2019. Staff confirmed that they understood and implemented documented hazard identification processes. The hazard registers sighted were current. The hazard register for each room / service or environment is laminated and displayed in each area for quick reference as observed during audit.</p> <p>Meetings are held every two months with residents to obtain resident feedback on services and for future planning. There is good attendance, and the minutes of the last two meetings were reviewed. Topics included (but were not limited to), activities, staffing, special events, the facility and meals. The results of the November 2019 residents' satisfaction survey were very positive about staff and the services received.</p> <p>Quality information is shared with all staff via shift handover (where applicable), as well as via the continuous quality improvement / infection prevention and control meetings, the health and safety meetings and the staff meetings. These committees meet two monthly and are scheduled in a manner to ensure appropriate flow of information to all staff. The minutes of the most recent meetings were displayed in the rest home staff office area. The minutes of the last two committee meetings were reviewed at audit and verified relevant information is communicated to staff. Staff interviewed verified that they were kept well informed of quality and risk issues, changes and trends. The monthly infection, complaints and incident/accident summary data was displayed in the rest home office.</p> <p>Staff and residents interviewed expressed a high level of satisfaction about the services provided at St Catherine's Rest Home.</p> <p>The executive manager advises she keeps updated with legislative changes via existing peer networks. Current applicable legislation is also detailed in the risk register.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by</p>	<p>FA</p>	<p>Policy and procedure detail the required process for reporting incidents and accidents including near miss events. Staff are provided with education on the responsibilities for reporting and managing accidents and incidents during orientation and as a component of the November 2019 annual mandatory staff training / education programme.</p> <p>Applicable events are being reported on the designated forms in a timely manner and disclosed to the resident</p>

<p>the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>and/or family / designated next of kin or support person. This was verified by residents interviewed and documentation in sampled residents' files. A register of all reported events over time is maintained in each resident's clinical record. A review of reported events in sampled residents' files included falls (with and without an injury), a resident that was absent without staff knowledge, and a medicine error, demonstrated that incident reports are completed, investigated and responded to in a timely manner.</p> <p>The executive manager and a member of the pastoral care team is on call after hours and is available to staff in the event of significant events or accidents / injuries to residents. Communication on appropriate issues was verified as occurring afterhours. Staff advise they communicate incidents and events to oncoming staff via the verbal shift handover.</p> <p>A summary of all reported events is discussed with staff at the staff meetings and at the continuous quality improvement/infection control meetings. The number and type of incidents per month and themes and trends over time is analysed and reported per 1000 occupied bed days.</p> <p>The executive manager identified the type of events that must be reported to external agencies as an essential notification and advised there have been no events requiring essential notification since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Copies of the annual practising certificates (APCs) for three general practitioners (GPs), four pharmacists, the podiatrist, the physiotherapist, the executive manager and the three other registered nurses (RNs) were sighted. Formal contracts are in place with the contracted registered health professionals (RHP's). The 'licence to operate a pharmacy' for the contracted pharmacy was current and was sighted.</p> <p>Recruitment processes include completing an application form, conducting interviews and reference checks, and police vetting (since 2016) and having a signed employment agreement. These records have been maintained for the two staff employed since the last audit. Staff have signed job description on file which are reviewed and re-signed annually during the performance appraisal process. This includes reviewing the responsibilities for the two RNs that are allocated the responsibilities for the infection prevention and control, privacy and restraint minimisation portfolios. The job description includes a statement advising staff of privacy / confidentiality requirements. Annual performance appraisals have occurred for all staff. The executive manager reports on these in the monthly reports to the governance groups.</p> <p>New employees are required to complete an orientation programme relevant to their role and records of this are now being maintained. A checklist is utilised to ensure all relevant topics are included. New employees are buddied with senior staff for at least two weeks and longer if required, until the new employee is deemed able to safely work on their own.</p> <p>An ongoing staff education programme is in place. An annual education study day is provided each year (last held in November 2019), that includes topics required to meet the provider's contract with ADHB and ensure staff competency. The study day is provided on two separate days in the designated month to ensure all staff</p>

		<p>attend. The topics included in the 2019 study day included complaints management, restraint minimisation, the use of enablers, managing challenging behaviours, fire safety / emergency procedures, pressure injury prevention/management, manual handling and use of the hoists, falls prevention, and undertaking neurological observations, privacy, and elder abuse and neglect. All staff attended the 2019 day. There is some variation in content from year to year, with the draft 2020 programme (commencing 1 April 2020) scheduled to be presented to the governance groups for approval. Staff are required to complete questionnaires following the annual study day as part of the education/competency assessment process, and the executive manager monitors to ensure that all staff complete the requirements, and formal evaluations are completed by all attendees. These records were sighted. Staff also attend relevant external education. Six caregivers are currently completing an industry approved qualification with five doing level three and one staff member working towards a level four qualification.</p> <p>Records of education are maintained. There is also an annual medicine, hand hygiene, chemical safety and wound care competency programme. The medicine competency programme includes oral medicines, blood glucose testing and management, nebulisers, and controlled drugs. All applicable staff have a current competency (November 2019).</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy details staffing levels and skill mix requirements (March 2020). The roster sighted demonstrated staffing meets the requirements of the provider's contract with Auckland District Health Board (ADHB). There were no staff vacancies.</p> <p>The current one-month roster was reviewed and demonstrated that there was an RN on duty eight hours a day, seven days a week. This is covered by three RNs. The executive manager is also an RN and on-site weekdays and on call when not on site. The executive manager and two other RNs have completed interRAI training and competencies. One RN is the CQI officer and is responsible for the infection prevention and control programme, with one day a week allocated for these responsibilities.</p> <p>A caregiver works weekdays 7am to 3pm, 3pm to 11pm, 4 pm to 9 pm and 11pm to 7 am. Another caregiver works weekdays 7am to 3pm undertaking caregiving duties for the initial part of the shift then facilitates the activities programme. On the weekends there is one caregiver on the morning, afternoon and night shift. Another caregiver works 8.30 to 12.30am and 4 pm to 9 pm. Members of the pastoral care team (not employees of St Catherine's), support residents by taking them to offsite appointments and on outings.</p> <p>The activities facilitator has allocated time weekdays. She works part of the shift as a caregiver then progresses to facilitating the activities programme (refer to 1.3.7).</p> <p>Additional staff hours are rostered for the food / kitchen services. The kitchen also provides meals for Mercy Hospice and caters for events / functions as needed. There is a cook / chef on duty each day 8.00 am to 5.00 pm. A kitchen assistant is on duty between 7 am to 2.30 pm, and another kitchen assistant from 2.00 pm to 7</p>

		<p>pm every day.</p> <p>The laundry is staffed two days a week (23 hours). A cleaner is rostered on duty 8 am to 4 pm Tuesday and Thursday in the rest home/convent. The cleaning of the other parts of the building are undertaken daily weekdays by designated staff that are not directly employed by St Catherine's. Caregiver staff assist with other cleaning throughout their shifts.</p> <p>The contracted physiotherapist is on site weekly for four hours. The podiatrist visits six weekly. The general practitioner routinely visits monthly.</p> <p>All staff have a current first aid certificate. There is always a staff member with a current first aid certificate and medicine competencies on duty.</p> <p>After the evening meal, residents stay on level three and four of the building. When there is one staff member on duty, they do hourly visual checks of all residents.</p> <p>The staff confirmed the executive manager is available out of hours if required. Residents and family members interviewed confirmed their personal and other care needs are well met, they 'lack for nothing', and their call bells are answered very quickly at all times.</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>	FA	<p>A resident register is maintained of all current and past residents. Resident individual information is kept in paper and electronic format. The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled. Clinical notes were current and integrated with the GP and allied health service provider notes. Written records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</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</p>	FA	<p>The entry to service policy includes all the required aspects on the management of enquiries and entry. Assessments and entry screening processes are documented and clearly communicated to the residents, family/whanau where appropriate, local communities and referral agencies.</p> <p>Records sampled confirmed that admission requirements were conducted within the required time frames and are signed on entry. Family/whanau and residents interviewed confirmed that they received sufficient information regarding the services to be provided.</p>

for services has been identified.		
<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>There is a documented process for the management of transfers and discharges. A standard transfer notification form from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Pastoral care team, residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</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>There is a documented policy on the management of the medication system. All medication files sampled confirmed that they were reviewed as required and discontinued medications are signed and dated by the GP. Allergies were documented, identification photos were present and three-monthly reviews were completed. Medication charts were legibly written. The RN was observed administering medication correctly.</p> <p>Medication reconciliation is conducted by the RNs when a resident is transferred back to the service either from hospital, appointments, or when there are any medication changes. The service uses pharmacy pre-packed packs that are checked by the RNs on delivery.</p> <p>The management of controlled drugs met the requirements of the standard; however, there were no controlled drugs in use at the time of the audit. The RN reported that routine weekly and six-monthly stock takes would be conducted if there were any controlled medication in stock. There are no vaccines stored on site.</p> <p>Residents self-administering medication are assessed as competent to do so and medication was stored in a secure way. There is a policy and procedure for self-administration of medication to guide staff.</p> <p>An annual medication administration competency is completed for all staff administering medications and medication training records were sighted (refer to 1.2.7). The medicines management system complies with legislation, protocols and guidelines.</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</p>	FA	<p>There was an approved food plan for the service. The food service was audited by the local council and given a food safety grade A (excellent) in April 2019. Meals are prepared on site and served in the allocated dining rooms. The menu was reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. There was a four-weekly rotating winter and summer menu in place.</p> <p>Residents' food preferences were developed on admission which identifies dietary requirements, likes and dislikes and was communicated to the kitchen including any recent changes made. Diets were modified as required and the cook confirmed awareness on dietary needs required by the residents. Meals were served</p>

<p>service delivery.</p>		<p>warm in sizeable portions required by residents and any alternatives were offered as required. The residents' weights were monitored monthly and supplements were provided to residents with identified weight loss of concern. Snacks and drinks were available for residents as and when required. The family members and residents interviewed acknowledged satisfaction with the food service.</p> <p>All food services staff have completed training in food safety/hygiene. The kitchen and pantry were clean, tidy and well stocked. Labels and dates were on all containers and records of food temperature monitoring, fridges and freezers temperatures were maintained. Regular cleaning was conducted.</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 RN reported that all residents who are declined entry are noted. When a resident is declined entry, family/whanau and the resident are informed of the reason for this and made aware of other options or alternative services available. The resident is referred to the referral agency to ensure that they will be admitted to the appropriate service provider.</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>FA</p>	<p>Residents have their level of care identified through a needs assessment by the assessment agency. Twenty-four-hour resident assessments are completed within the required time frame on admission while residents' care plans and interRAI assessments are completed within three weeks according to policy. Assessments and care plans were detailed and included input from the family/whanau, residents and other health team members as appropriate. Additional assessments are completed according to the need; these included pain, behavioural, falls risk, nutritional requirements, continence, skin and pressure assessments. In interviews conducted, family/whanau and residents expressed satisfaction with the assessment process.</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>FA</p>	<p>The assessment findings in consultation with the resident and/or family/whanau, inform the care plan and assist in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Short term care plans are used for short-term needs. Family/whanau and residents interviewed confirmed they are involved in the care planning process. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the resident such as the mental health services for older people, district nurses, physiotherapist, podiatrist, dietitian and 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>	FA	<p>Interventions are adequate to address the identified needs in the care plans. The RN reported that significant changes are reported in a timely manner and prescribed orders carried out. Medical input is sought from the GP in a timely manner, medical orders are followed, and care is person centred. Evidence of six weekly visits by the podiatrist were sighted in files sampled. Care staff confirmed that care is provided as outlined in the care plan. A range of equipment and resources are available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Activities are appropriate to the needs, age, culture and religious beliefs of the residents. The activities coordinator develops an activity planner and daily/weekly activities are posted on the notice boards. Residents' files have a documented activity plan that reflects the resident's preferred activities of choice. The residents attend mass at 11.15 am daily in the chapel on-site. Over the course of the audit, residents were observed being actively involved in a variety of activities. Activity plans are reviewed at least three monthly or when there is any significant change in participation, and this is completed in consultation with the RN. The activities vary from scrabble, bingo, music, Tai-chi exercises/walking, daily mass and church services every weekend. The activities coordinator reported that they have group activities and engage in one on one activities with some residents. Activities are modified according to abilities and cognitive function. The physiotherapist visits every Wednesday for three hours.</p> <p>The community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate) with the pastoral care team. Residents and family members interviewed reported satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is documented on each shift by care staff in the progress notes. The registered nurses complete progress notes weekly or as necessary. All noted changes by the care staff are reported to the RNs in a timely manner.</p> <p>Formal care plan evaluations, following interRAI reassessments to measure the degree of a resident's response in relation to desired outcomes and goals, occur at three and six-monthly intervals or as a resident's needs change. These are carried out by the RNs in consultation with family, GP and specialist service providers. Where progress is different from expected, the service was seen to respond by initiating changes to the service delivery plan.</p> <p>Short term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes.</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>	FA	<p>Residents and family/whanau are supported to access or seek referral to other health and/or disability service providers where required. If the need for other non-urgent services are indicated or requested, the GP and the nursing team sends a referral to seek specialist services assistance from the district health board (DHB). Referrals are followed up on a regular basis by the registered nurses or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to the public hospital in an ambulance if required. Residents are assisted to access dental services.</p>
<p>Standard 1.4.1: Management Of 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>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Chemicals are stored securely. Safe chemical handling training and education is undertaken as part of the staff in-service education programme, most recently in January/February 2020. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of appropriate protective clothing and equipment as confirmed by staff during interview. Staff were observed wearing PPE appropriately. A spill kit is present in the rest home.</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 (expiry date 02 June 2020) was sighted. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. The provider has increased the number of certified beds by one to 15. A review of the 21 bedrooms verify all are suitable for the provision of rest home level of care. The executive manager is responsible for ensuring maintenance requests are undertaken. This includes using contractors where required. Calibration of bio medical equipment has occurred as confirmed in documentation reviewed or the equipment is newly purchased. The temperature of hot water is tested monthly with all 21 bedrooms/bathrooms tested on a rotating basis. The temperature of the hot water was within the required temperature range. The environment was hazard free, residents advised they felt safe and their independence was promoted. Grab rails are present in the bathroom and corridors.</p> <p>External areas are safely maintained and are appropriate to the resident group and setting. The external</p>

		<p>courtyard on the second level has had the paving replaced with a deck that aligns with the floor level. New furniture and shade have been purchased for this area. There is another external courtyard nearer the chapel.</p> <p>Residents and families interviewed had no concerns related to the internal or external environment. Residents were sighted mobilising independently or with assistance of staff and/or a mobility device throughout the building. There are chairs located along the corridor and in the elevators so residents can sit down if they need/want to.</p> <p>Significant refurbishment / renovations have occurred. This included replacing the hot water, the heating / air-condition system in the building. New carpet tiles have been installed in St Catherine's rest home and St Mary's convent. The accommodation space that has not been used for several years has been renovated and is now 11 apartments for sisters of faith to independently live in (refer to 1.2.1). These apartments are not included in the scope of this certification audit. The architect/project manager advised the final code of compliance documents related to this work are currently with Auckland City Council and are expected to be progressed within the next two weeks. The fire evacuation plan has not been required to be updated as the egress routes have not changed, and these areas have historically been used for accommodation.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>All bedrooms have an ensuite with a toilet, shower and handbasin. There are other toilets available for staff, and visitors. There are toilets accessible to residents near the dining room and chapel. Grabrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Privacy locks and appropriate signage is on bathroom facility doors. Waterless hand hygiene products are readily available.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. This was confirmed during staff interviews. All bedrooms were single occupancy. Rooms were personalised with furnishings, photos and other personal items displayed. Residents and family members confirmed their satisfaction with their bedrooms. Mobility aids are kept in residents' bedrooms.</p>

consumer group and setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. Refer to 1.2.1 and 1.4.2. There are adequate dining, lounge and other recreational areas, which cater for all residents' dining, spiritual and relaxation needs. Residents can access areas for privacy, if required. The furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry. There is also a small laundry with a washing machine and drier on level three and level four (in the rest home and convent). These are used to rinse/wash soiled linen so there is no delay in washing. The staff member responsible for laundry services was interviewed, and demonstrated a sound knowledge of the laundry processes, dirty to clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are washed, dried and returned the same day. There is a drying room where more delicate items can be safely dried.</p> <p>The cleaner confirmed she had received appropriate training including chemical safety. The facility looked and smelled clean. Chemicals were stored in locked cupboards and were in appropriately labelled containers. Cleaning and laundry processes are monitored through internal audits, and resident satisfaction surveys.</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>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency.</p> <p>The fire evacuation plan was approved by the New Zealand Fire Service on the 31 January 2004. A trial evacuation takes place at least six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in November 2019 as part of the staff mandatory training. The mandatory training including other emergency events/scenarios. The orientation programme includes fire and security training.</p> <p>Staff confirmed their awareness of the emergency procedures. There is always at least one staff member on duty with a current first aid certificate. Supplies for use in the event of a civil defence emergency, including food, water, spare blankets, personal protective equipment, and clinical consumables, were sighted and meet</p>

		<p>the requirements for up to 21 residents/sisters. Enough bottled and tank water supply is available.</p> <p>Call bells alert staff to residents requiring assistance and alert audibly to centralised panels as well as via an illuminated light outside the applicable door. Some residents carry personal pendants so they can call for staff when they are away from their room. Call bells have also been installed in the dining room, and physiotherapy room. Residents and families reported staff responded promptly to call bells.</p> <p>The main entrance (ground floor) of the building is kept locked. There is an intercom at the door that visitors can use to call for access. Staff in St Catherine's can see who is at the door before granting access remotely. Residents and staff wear pendants that unlocks the door. Residents were very satisfied with security arrangements and access to the building and had no difficulty leaving the building as required (refer to 1.1.3).</p> <p>There are security cameras in use that monitor the external areas of the building. Security images are archived and accessible onto to authorised personnel. Staff advise they lock the door and close the windows (if applicable) at designated times. The windows sighted have 'security stays' installed. The caregiver on night duty also undertakes a regular security check to ensure all doors and windows are appropriately secured, and all residents are checked on an hourly basis or sooner where applicable.</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>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided by wall mounted electric heaters in residents' rooms and ceiling heating in the communal areas. Areas were appropriately warm and well ventilated throughout the audit and residents and families interviewed on this topic confirmed the facilities were maintained at a comfortable temperature regardless of the season and weather.</p> <p>There is no smoking on site.</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</p>	<p>FA</p>	<p>The service has implemented an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a current infection control manual, with input from external specialists. The infection control programme was reviewed annually and was incorporated in the bi-monthly meetings and a review of the education programme was conducted.</p> <p>The continuous quality improvement coordinator who is also a registered nurse is the designated infection prevention and control coordinator (IPCC), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results are reported monthly to the executive manager and to the bi-monthly staff and board meetings. Quality meetings are held every two months and involve the IP&CC, activities coordinator, food service manager, care staff representative and a cleaner.</p>

<p>scope of the service.</p>		<p>The infection control manual provides guidance for staff on how long they must be away from work if they have been unwell. Staff interviewed understood these responsibilities. Vaccination is encouraged for staff and residents.</p> <p>There is information that covers aspects of infection control for family/whanau and if they are unwell; it is recommended that they do not visit the service. During higher risk times of community infections and winter months, notices were placed at the door to remind people not to visit if they are unwell. There was sanitising hand gel at the entrance and throughout the service. Hand washing and sanitiser dispensers were readily available around the facility. Supplies of personal protective equipment are reserved for use in an outbreak.</p> <p>No infection outbreak has been reported since the previous audit. Information on the management of the novel coronavirus (Covid 19) was readily available for staff and visitors.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection prevention and control coordinator (IPCC) has appropriate skills, knowledge and qualifications for the role and has attended specific education related to infection prevention and control.</p> <p>Additional support and information are accessed from an external infection control agency, the infection control team at the DHB and the GP as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The coordinator confirmed the availability of resources and external specialists to support the programme and any potential outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures</p>	<p>FA</p>	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. The policies and procedures are developed by the organisation with advice from external specialists. Policies were current and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Staff interviewed verified knowledge of infection control policies and practices.</p>

are practical, safe, and appropriate/suitable for the type of service provided.		
<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>Staff education on infection prevention and control is conducted by the IP&CC and other specialist consultants. The infection prevention and control coordinator attended infection prevention and control training conducted by an external consultant to keep their knowledge current. A record of attendance is maintained and was sighted. The infection prevention and control training education information pack is detailed and meets best practice and guidelines. External contact resources included the GP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</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 infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. Monthly surveillance data is sent through to the executive manager and to the board. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are implemented. Staff interviewed reported that they were informed of infection rates at bi-monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively. This was confirmed in documents reviewed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards. Restraint can only be considered if all other options have been considered and is a last resort. The restraint coordinator (the fulltime RN) has been in the role since January 2017, provides support and oversight for enabler and restraint minimisation processes, and verbalised an understanding of the organisation's policies, procedures and practice, and the restraint minimisation coordinator role and responsibilities. Caregivers interviewed could describe enablers and restraints and verified these have not been used 'for a long time'. The restraint coordinator advised restraints have not been used since her appointment.</p> <p>Staff have been provided with orientation and ongoing training on restraint minimisation and enabler use. In-service education occurred in November 2019 as part of the mandatory staff study day programme. Staff completed a questionnaire as part of the competency assessment programme.</p> <p>On the day of audit, no residents were using either restraints or enablers as verified by staff interview and observation.</p> <p>The main door into the building is kept locked. Residents and staff have pendants to enable freedom of</p>

		movement/access (refer to 1.4.7). This does not restrict residents' freedom of movement and is not considered as environmental restraint.
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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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.