Little Sisters of The Poor Aged Care New Zealand Limited - Sacred Heart Home and Hospital

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 BSI Group New Zealand Ltd, 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:	Little Sisters of The Poor Aged Care New Zealand Limited
Premises audited:	Sacred Heart Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 3 November 2021 End date: 3 November 2021
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:	50

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Sacred Heart Home and Hospital is certified to provide rest home and hospital – geriatric and medical level care. The service is governed by the Little Sisters of the Poor NZ Trust Board and the Christian philosophy is embedded in the business plan. The service provides care for up to 53 residents with 50 residents on the day of audit.

This unannounced surveillance audit was conducted against the Health and Disability Service Standards and the district health board contract. The audit process included a review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

Sacred Heart Home and Hospital is managed by a Mother Superior, she is supported by a clinical nurse manager and an assistant manager. The service is overseen by a chief executive officer who reports to a Board of Directors. The management team receives support from Sisters living at Sacred Heart, administration staff, registered nurses and care staff. The residents, relatives and the GP interviewed all spoke positively about the care and support provided.

Residents and families interviewed were complimentary of the service that they receive. Staff turnover has been low for care workers.

This audit has identified shortfalls around quality data, staff appraisals and medication storage.

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.

Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including when a resident is involved in an incident or has a change in their current health. There is an established system implemented for the management of complaints.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

There is a business plan with goals for the service that is regularly reviewed. An established quality and risk system is in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has a training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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

The registered nurse assesses, plans, reviews and evaluates residents' needs, outcomes and goals with the resident and/or family/whānau input and are responsible for each stage of service provision. Care plans demonstrate service integration and were evaluated at least six monthly. Resident files are electronic and included medical notes by the general practitioner, and allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurse and medication competent caregivers are responsible for administration of medicines. All staff are responsible for medication administration complete annual education and medication competencies. The medicine charts reviewed met prescribing requirements and were reviewed at least three monthly by the general practitioner.

The activity team provide and implement an interesting and varied integrated activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and resident preferences.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site.

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 form 12a has been issued by the Dunedin City Council in place of a Building Warrant of Fitness on 8 April 2021 and is valid for 12 months. There is a planned and reactive maintenance programme in place. There are documented processes for the management of waste and hazardous substances in place. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade.

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.

Sacred Heart has policies and procedures on safe restraint use and enablers. A registered nurse is the restraint coordinator. On the day of the audit, there were six residents using restraint and four residents using enablers. Staff receive training around restraint and managing challenging behaviours. Assessment and evaluation processes are implemented, and the service continually reviews restraint to minimise use where possible.

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 surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control responsibilities are shared between a registered nurse and the clinical nurse manager. Infection control data is collated monthly and outcomes and actions are discussed at the quality, and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. The surveillance of infection data assists in evaluating compliance with infection control practices. There have been no outbreaks since the previous audit.

Adequate supplies of personal protective equipment were sighted. All visitors and contractors are required to complete wellness declarations and complete contract tracing requirements.

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	13	0	3	0	0	0
Criteria	0	38	0	3	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy/procedure in place and the complaints process is provided to residents and relatives on entry to the service. Complaints forms are available to residents and relatives near the entrance. A record of all complaints is maintained in the complaint register. The facility manager (mother superior) leads the investigation into complaints with support from the clinical nurse manager and assistant manager. Two complaints from 2020 and two complaints from 2021 (year-to-date) were reviewed and reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. All complaints/concerns have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaints to the satisfaction of the complainants. Residents and family members advised that they are aware of the complaint's procedure. Staff interviewed (four caregivers, two registered nurses, two activities coordinators, one HR advisor, one maintenance and one chef) confirmed discussions are held around concerns, complaints and compliments at staff meetings, which was evident in quality and staff meeting minutes. There have not been any complaints received from external providers since the last audit.
Standard 1.1.9:	FA	Interviews with three relatives (one hospital, two rest home) and five residents (three hospital, two rest home) confirmed they were welcomed on entry and were given time and explanation about services and procedures.

Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		Relatives interviewed also stated they are informed of changes in health status and incidents/accidents. This was confirmed on 12 incident forms reviewed. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, then interpreter services are made available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Sacred Heart provides residential services for up to 53 residents requiring rest home and hospital – geriatric and medical level care. On the day of the audit there were 50 residents (34 hospital and 16 rest home), all under the age-related residential care contract. There are 24 dual-purpose beds, suitable for either rest home or hospital level of care. Sacred Heart has a mission, philosophy, commitments and objectives which together form the basis of the care provided to residents. The facility is governed by a mission board located in Auckland. A business/quality/risk management plan is in place. The goals and direction of the service are well-documented and progress towards meeting these goals are documented through reports to the board, and in the monthly quality meeting minutes. The facility manager/mother superior studied nursing overseas but does not hold a New Zealand practising certificate. She was unavailable during this spot surveillance audit. The facility manager is supported by a clinical nurse manager/registered nurse (RN) who has been in the role for three years and has worked at the facility for six years; and an assistant manager/sister/RN who has been in the role since 2018. The managers have each completed in excess of eight hours of professional development over the past twelve months.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement	PA Low	Sacred Heart has a quality and risk management system established. The managers oversee the quality programme with input and involvement from the staff, confirmed in interviews with the managers and staff. Policies and procedures implemented provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Sacred Heart is in the process of implementing policies developed by an external consultant (Health Compliance Solutions Ltd). Staff sign to confirm that they have read and are aware of any new/revised policies. Quality improvement processes are established, capture and manage non-compliances. This includes internal audits, hazard management, risk management, incident and accident, infection control data collection and

principles.		complaints management. Missing was evidence of annual resident/relative satisfaction survey results. Quality improvement data is discussed and minuted in the monthly quality meetings and three-monthly staff meetings. Corrective actions are developed, implemented and signed off when service shortfalls are identified. There is an implemented health and safety programme in place including policies to guide practice. The health and safety programme is linked to the quality and staff meetings as a regular agenda item. Hazard registers are regularly reviewed and audited internally every six months to ensure a safe environment. Staff confirmed they are kept informed on health and safety matters at meetings. Falls prevention strategies are in place. A physiotherapist is on site from 0900 – 1200, four days a week and is assisted by physiotherapy students. Examples of falls management strategies include intentional rounding, regular toileting, sensor mats, and decluttering rooms. Each resident has an individual transfer plan that is regularly updated.
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	The service collects incident and accident data. These are collated monthly and are discussed at the staff meetings and quality meetings. Twelve electronic incident forms covering witnessed and unwitnessed falls, bruising and episodes of challenging behaviours were reviewed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations are conducted for unwitnessed falls and any known head injury. The next of kin is notified as indicated on the incident/accident form and/or in the resident's progress notes. The caregivers interviewed could discuss the incident reporting process. The clinical nurse manager signs off on all incident/accident reports following their review and ensures corrective actions (as required) are implemented. The assistant manager and clinical nurse manager interviewed could describe situations that would require reporting to relevant authorities. There has been one section 31 report completed since the previous audit for a resident with challenging behaviours.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of	PA Low	There are policies to guide recruitment and employment practices. A human resources (HR) advisor oversees HR processes. Appropriate recruitment and employment documentation were evidenced in the six staff files reviewed (four caregivers, one kitchen assistant and one housekeeper) including evidence of an interview and reference checking, police vetting, signed employment contracts and signed job descriptions. Performance appraisals were missing in a selection of staff files. Interviews with staff informed that management are supportive and responsive. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. An education planner covers compulsory education requirements over a two-year period. Six

legislation.		of nine RNs have completed interRAI training. There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to): medication management, syringe driver training and associated competencies. Five caregivers have completed their level three CareerForce qualification (or its equivalent) and two have completed a level four qualification. Three caregivers are international RNs. There is a minimum of one first aid trained staff available at all times on site and on outings. Current practicing certificates are retained for the RNs, ENs and other registered health professionals. Residents and families stated that staff are knowledgeable and skilled.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Sacred Heart Home and Hospital has a documented rationale for determining staffing levels and skill mix for safe service delivery. There is a registered nurse on duty at all times and at least one staff member on with a current first aid qualification. The sisters (one mother superior, one assistant manager/RN and one caregiver) live on site and provide afterhours/on call support as required. The clinical nurse manager/RN is employed Monday – Friday. At the time of the audit there were 2.5 full time equivalent (FTE) caregiver vacancies and 1.0 FTE RN vacancy. The dual-purpose rest home/hospital wing, known as the villas, includes rest home and (low acuity) hospital level residents. There were 24 residents (9 hospital and 15 rest home) in the villas at the time of the audit. An EN is rostered five days a week on the morning shift with a senior caregiver filling in on the days the EN is unavailable. A senior caregiver is rostered on the afternoon shift five days a week with a casual RN filling in on the days the senior caregiver is unavailable. The night shift is staffed with one RN who is based in the hospital wing. There are three caregivers (one long shift and two short shifts to 1315). On the afternoon shift there are two caregivers (to 2130). When the caregivers leave, a caregiver from the hospital covers the villas until the night staff arrive. The night shift is staffed with one caregiver. In the hospital wing with 26 residents (25 hospital and one rest home) there is a staff RN on every shift. The assistant manager/RN provides oversight in addition to the clinical nurse manager. The RN is supported on morning shift by five caregivers (three full shifts and three short shifts). On afternoon shift there are four caregivers (two short and two long shifts). On night shift there is one caregiver. Note: the rest home level resident in the hospital has been placed there under special circumstances, to provide support for a palliative resident. The service employs cleaners, laundry staff and kitchen staff including cooks and kitchenhands. The manager (mother superior) and assistant manager/RN (sister) each work approximately 40 hours per week, live on site and are available to support staff as required including during the PM and night shifts. Caregivers reported that staffing levels and the skill mix was adequate although very busy. Residents and

		family members interviewed advised that they felt there was sufficient staffing.
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.	PA Low	The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All medicines are stored securely. The medication fridge temperatures are monitored and recorded; however, medication room temperatures were not being monitored. Checking for the temperature of the medication room was commenced on the day of the audit. Registered nurses, enrolled nurses and senior caregivers' complete annual medication competencies and medication education. Medication reconciliation occurs against the robotic rolls (for regular medications) and blister packs (for 'as required' medications). The GP reviews and signs a list of standing orders annually. Records of medication reconciliation are entered into the electronic medication system. Any discrepancies are fed back to the supplying pharmacy who are available after hours if required. There were two rest home residents self-medicating with current self-medication competencies. All eyedrops were dated on opening. Ten electronic medication charts were reviewed. All charts had photo identification and allergy status documented. 'As required' medication has documented indications for use. The effectiveness of 'as required' medications were recorded in the electronic medication system. All long-term medications charts had been reviewed by the GP three monthly.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals are prepared and cooked in the Sacred Heart Home and Hospital kitchen. The Food Control Plan is current until 31 March 2022. The chef is qualified with City and Guilds. He runs his own food safety programme for staff based on food control documentation. All kitchen staff have a food handling certificate. The kitchen team includes two chefs and a back-up cook and kitchenhands. There is a rotating menu that is designed and reviewed by an external company that specialise in providing menus for rest homes and provide dietitian expertise. A food services policies and procedure manual is in place. There are two dining rooms for residents. Food is transported to the kitchen areas adjacent to each dining room in hot boxes, then transferred to bain maries, probed and served. Daily hot food temperatures are taken and recorded for each hot meal. Meals are served and delivered to residents. Fridge and freezer temperatures are recorded. Dry foods in the pantry are dated and sealed. Perishable foods in the chiller and refrigerators are date-labelled and stored correctly. The kitchen is well equipped with a separate dishwashing area, preparation, cooking, baking and storage areas. Cleaning schedules are maintained. The chemicals are stored safely. The chemical supplier completes quality control checks on the sanitiser. Safety data sheets are available, and training is provided as required.

		Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves. All residents have their dietary requirements/food and fluid preferences recorded on admission and updated as required. The chef maintains a folder of residents' dietary requirements that include likes/dislikes. Alternative choices are offered. The chef is informed of dietary changes and advised of any residents with weight loss. Dietary needs are met including normal, pureed meals and finger foods. Specialised utensils and lip plates are available as required. Input from residents and food surveys, provide resident feedback on the meals and food services (link 1.2.3.6). Residents and relatives interviewed confirmed likes/dislikes are accommodated and alternative choices offered. The residents and relatives interviewed were complimentary of the food services.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The electronic care plans reviewed were goal orientated and met the resident needs. Residents and relatives interviewed stated their needs are being met. If a resident's condition changes the RN initiates a GP consultation or nurse specialist referral. There were six residents with wounds on the day of the audit including skin tears, surgical wound, and chronic venous ulcers. Wound assessments had been completed electronically for all wounds including a body map, sizes and photos as required. Evaluations and change of dressings had occurred at the documented frequency. Chronic wounds had been linked to the long-term care plan. There were no residents with pressure injuries. The RNs have accessed advice and support from the wound nurse specialist and the vascular clinic at the DHB for the chronic ulcers. There was sufficient pressure relieving devises in use and available. There is specialist continence advice as required. Sufficient continence products were sighted during the audit. Monitoring records sighted included weights, vital signs, neurological observations, bowel records, food and fluids, blood sugar levels, pain, two hourly repositioning charts, fluid balance and challenging behaviour monitoring charts. Resident weights were noted to be monitored monthly or more frequently if necessary.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the	FA	The two activities assistants are employed Monday to Friday and a Saturday afternoon. Both team members are undertaking training in diversional therapy and building on their existing skills and qualifications. Staff facilitate activities for residents on Sundays and this includes videos and concerts with visiting entertainers. Resident files reviewed demonstrated that the activities team conduct an activities assessment on admission and six monthly thereafter. Plans are developed, reviewed, evaluated and integrated into the resident's care plan. Residents interviewed confirmed that the activities provided by the facility met their needs. The sisters from Little Sisters of the Poor provide ongoing spiritual and pastoral care to residents, and the on-

setting of the service.		site chapel enables residents to attend church services and communion. The activities programme is made available to residents in A3 format for ease of reading and is displayed on noticeboards around the facility. The Little Sisters of the Poor also prepare a weekly 'Chatline' newsletter with activities and spiritual input. The activity programme includes newspaper reading, exercises, arts and crafts, group games, knitting groups, and movies. The activities team enable residents to access the community through bus outings. Bus outings include going to beaches and nearby attractions (Covid restrictions allowing). The bus driver holds a current first aid certificate. The residents can provide feedback on the programme at the completion of each activity, through resident meetings, surveys and one-to-one interactions (link 1.2.3.6). The registered nurses, residents and relatives interviewed commented positively on activities offered.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The initial care plan is evaluated in consultation with the resident/relative and long-term care plans developed. Long-term care plans reviewed had been evaluated six monthly or earlier for any changes to health. The residents/relatives are invited to attend the multidisciplinary review (MDT) with input from the GP, physiotherapist, activities coordinator, and the registered nurses. There is a written evaluation against the resident goals that identifies progression towards meeting goals. Long-term care plans are updated with any changes to meet the resident goals. Short-term care plans were evident for the care and treatment of short-term problems for residents and these had been evaluated, closed or transferred to the long-term care plan if the problem was ongoing.
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 Chubb building systems status report is posted in a visible location (4 March 2021). The Dunedin City Council is delayed in issuing a building warrant of fitness document due to the Covid pandemic. A form 12a has been issued on 8 April 2021 and is valid for 12 months. Two maintenance staff carry out minor repairs and maintenance, reactive and preventative maintenance. There is an annual maintenance plan, with monthly checks, which include hot water temperatures, maintenance of equipment and safety checks. Electrical equipment is tested and tagged a minimum of annually. Clinical equipment is calibrated annually. Essential contractors are available after hours. The corridors are sufficiently wide to enable safe mobility for the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas. The facility has a van available with a current warrant of fitness and registration for transportation of residents.

		The caregivers and RNs stated they have enough equipment to safely deliver the cares as outlined in the resident care plans. There are adequate storage areas for hoist, wheelchairs, products and other equipment.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control responsibilities are shared between a registered nurse and the clinical nurse manager oversees practice and collates the monthly data. The clinical nurse manager uses the information obtained through surveillance to determine infection control activities, trends, resources, and education needs within the facility. An individual electronic resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly and outcomes and actions are discussed at the quality, and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. There have been no outbreaks since the previous audit. The clinical nurse manager and registered nurse interviewed were knowledgeable around the management, documentation and reporting of an outbreak. Staff were observed to be wearing appropriate personal protective equipment (PPE). Staff were also observed to have the ability to ensure that the five moments of hand hygiene were performed when undertaking personal cares in residents' rooms. Any reusable PPE is wiped between use. All resident rooms have ensuite facilities; care staff interviewed described handwashing and PPE requirements during resident cares. The service has Covid resource information available to staff, which includes guidelines, and requirements for each level of Covid-19 lockdown. There is signage at the entry of the facility to remind visitors not to visit if they are feeling unwell. As the audit was conducted during level 2 Covid restrictions, all visiting was arranged by appointment only. All visitors are required to sign in at the reception, complete a wellness declaration and wear a mask. Adequate supplies of personal protective equipment were sighted and is accessible to staff. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service.
Standard 2.1.1: Restraint minimisation	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There were six hospital residents with restraints (lap belts, bedrails) and four hospital level residents with enablers (bedrails). Policies and procedures include definitions of restraint and enabler that are congruent with the

Services demonstrate that the use of restraint is actively minimised.		definition in NZS 8134.0. Enablers are voluntary and require resident consent. Enabler documentation for one file reviewed included consent, risk assessment, care planning, and review. Staff education on RMSP/enablers is provided on orientation of new staff and annually thereafter.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	A quality improvement programme is established. Quality data that is collected and trended includes clinical indicator data, internal audit results, accident/incidents, hazards and complaints (if any). These results are regularly communicated to staff. The resident/relative satisfaction survey is scheduled to take place annually but was last conducted in 2019. Resident /family participation via resident meetings is scheduled six-monthly although the last meeting minuted was in 2019 (note: one meeting reportedly took place in 2020 and one in 2021 but the minutes were not located).	There is only minimal evidence of resident /family participation. A resident/relative satisfaction survey was last conducted in 2019 and resident /family meetings have not been held since 2019.	Ensure that residents and relatives have input into the quality programme e.g. through satisfaction surveys and regular resident/family meetings. 90 days

Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	A staff education and training programme is being implemented that reflects high attendance at scheduled in-services. Missing is evidence of annual performance appraisals.	Two of four staff files reviewed of staff who have been employed for over one year failed to reflect evidence of an annual performance appraisal. The HR advisor confirmed that staff performance appraisals are behind schedule.	Ensure staff performance appraisals are completed annually as per policy. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	Medications were stored securely, and medication trolleys were locked when not in use. Medication fridge temperatures were monitored and recorded, however, there was no documented evidence that medication room temperatures were being monitored.	There was no documented evidence that medications were stored under the recommended 25 degrees Celsius.	Document evidence that all medications are stored under 25 degrees Celsius. 90 days

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.

No data to display

End of the report.