

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

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand 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:	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: 27 June 2019 End date: 28 June 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	48



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 48 residents on the day of audit.

This certification 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, two assistant managers (sisters) and a clinical nurse manager. The management team receives support from Sisters living at Sacred Heart, administration staff, registered nurses and care staff. The residents and relatives interviewed all spoke positively about the care and support provided. Mother Superior reports to Mother Provincial who oversees seven facilities in Australia, NZ and the Pacific area. The service is overseen by a chief executive officer who reports to a Board of Directors.

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

The service has fully attained all required standards.

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.
--	--	--

The staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is provided and discussed with residents and relatives. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

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.
---	--	--

There is a business plan with goals for the service that has been regularly reviewed. Sacred Heart Home has a fully implemented, robust quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. 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.		Standards applicable to this service fully attained.
--	--	--

An admission package with information on the services provided at Sacred Heart Home and Hospital is available prior to or on entry to the service.

Registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the general practitioner and visiting allied health professionals. There is a three-monthly general practitioner (GP) review.

The residents' activities programme provides varied activities that include one-to-one and group activities, community involvement and outings.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines complete annual education and medication competencies. All medication charts have photo identification, allergy status and evidence of three-monthly reviews noted.

All meals are prepared on site within the Sacred Heart Rest Home and Hospital kitchen. There is a Food Control Plan in place. The menu has been reviewed by a dietitian. Individual and special dietary needs and residents' dislikes are catered for and alternative options are made available for residents.

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.
--	--	--

Sacred Heart Home and Hospital has a current building warrant of fitness. All rooms are single and personalised, and some have a toilet and hand basin, and some have an ensuite. There is adequate room for the safe delivery of hospital and rest home level of care within the residents' rooms. Residents can freely access communal areas using mobility aids. There are communal dining areas, multiple lounges, a chapel, a library and recreational area with a stage, a shop and seating areas within the hallways. Outdoor areas and the internal courtyards are safe and accessible for the residents. There is wheelchair access to all areas.

Housekeeping staff maintain a clean and tidy environment. All laundry is completed at Sacred Heart Home and Hospital. Chemicals were stored safely throughout the facility. Appropriate policies are available along with product safety charts.

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 seven residents using restraint and seven residents using enablers. Staff receive training around restraint and 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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events.

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	50	0	0	0	0	0
Criteria	0	101	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>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in visible locations throughout the facility. The policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Interviews with staff (four healthcare assistants, two registered nurses, one clinical nurse manager and three activities staff), reflected their understanding of the key principles of the Code.</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 consent.</p>	FA	<p>Residents and their families are provided with all relevant information on admission. Policies and procedures for informed consent and resuscitation are in place. General consents and specific consents as applicable are obtained on admission and updated as required. These were sighted in the seven residents' files reviewed (five hospital files and two rest home files). Resuscitation plans were appropriately signed. Copies of enduring power of attorney (EPOA) for care and welfare were in resident files for residents deemed incompetent to make decisions.</p> <p>Systems are in place to ensure residents, and their family/whānau (where appropriate), are provided with appropriate information to make informed choices and decisions. Discussions with staff confirmed consent is obtained when delivering care. A signed admission agreement was in place for the files reviewed. Discussions with family/whānau confirmed that the service actively involves them in decisions</p>

		that affect their relative's lives.
<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	Residents have a documented enduring power of attorney on file (EPOA) if they cannot self-advocate. Contact numbers for advocacy services are in advocacy pamphlets that are available in the entrance. Residents' meetings include actions taken (if any) before addressing new items. Discussions with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions.
<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	Residents and relatives confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community. Entertainers are regularly invited to perform at the facility.
<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>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. 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 manager.</p> <p>Three complaints from 2018 and five complaints from 2019 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 evidence resolution of the complaints to the satisfaction of the complainants. Changes to resident's care plans have been made following complaints and meetings with family. Residents and family members advised that they are aware of the complaint's procedure. Discussion around concerns, complaints and compliments are evident in facility meeting minutes.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Six residents (two rest home and four hospital) and six relatives (two rest home, four hospital) interviewed, identified they are well-informed about the Code. Resident meetings in each unit and surveys provide the opportunity to raise concerns. Advocacy and Code of Rights information is

		included in the information pack and are available at the service.
<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>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents interviewed confirmed staff respect their privacy and support residents in making choice where able. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. Staff education has been provided on privacy dignity and abuse and neglect.</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	<p>The service has a Māori health plan and an individual's values and beliefs policy which includes cultural safety and awareness. Tikanga best practice guidelines are available to staff including a flip chart in nurses' stations. Residents who identify as Māori have their cultural needs addressed in care plans. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. Interviews with staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. The service has links to the DHB for cultural support as needed. Cultural training is included in the bi-annual training for staff.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents and family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>There are policies and procedures for staff around maintaining professional boundaries and code of conduct. The employment agreement includes a code of conduct. Job descriptions include responsibilities of the position. Interviews with care workers confirmed their understanding of professional boundaries, including the boundaries of the care workers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned.</p>

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has implemented policies and procedures that provide a good level of assurance that it is adhering to relevant standards. Healthcare assistants and registered nurses (RNs) have access to internal and external education opportunities. Regular facility and clinical meetings and shift handovers enhance communication between the teams and provide consistency of care. Sacred Heart employs a physiotherapist for four days a week, who completes resident mobility assessments and provides safe manual handling training for staff. All residents and families speak positively about the care provided.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Relatives interviewed stated they are informed of changes in health status and incidents/accidents. This was confirmed on incident forms reviewed. Residents also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur in each of the three units. 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	<p>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 48 residents, all under the Aged Residential Care contract. There were 26 residents in the hospital unit and 22 residents in the dual-purpose wing (16 rest home and six hospital level care). There were no respite residents.</p> <p>Sacred Heart has a mission, philosophy, commitments and objectives which together form the basis of the care provide to all residents. The facility is governed by a mission board located in Auckland. A business, quality and risk management plan describes the five key goals of the facility (consumer focus, provision of effective programmes, certification and contractual requirements, risk management and continuous improvements). Each goal describes the objectives, management controls, measurements and allocated responsibility. Goals are monitored annually by the quality improvement team. The Mother Superior (registered nurse) oversees the running of the facility with clinical management delegated to a clinical nurse manager. The clinical nurse manager has been in the role for the past year and has previously worked as a registered nurse at the facility for three years.</p> <p>Mother Superior (facility manager) and the clinical nurse manager have completed in excess of eight hours of professional development in the past twelve months. The goals and direction of the service are well documented in the business plan and the progress toward previous goals has been documented through reports to the board, staff meeting and regular staff communication.</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>	<p>FA</p>	<p>In the absence of the Mother Superior, an assistant manager (sister) provides cover, with support from the Sacred Heart office team, the clinical nurse manager and the registered nurses.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Sacred Heart is implementing a quality and risk management system. The Mother Superior and the clinical nurse manager oversee the quality programme. The business, quality and risk management plan includes goals for 2019. The previous year's plan has been reviewed.</p> <p>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. Staff sign as confirmation they have read and are aware of any new/reviewed policies.</p> <p>Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident, infection control data collection and complaints management. Each RN has a portfolio that they have responsibility for as follows: wounds adverse events, infections, restraint and enablers and education. All quality improvement data is discussed at three monthly staff meetings in each unit and monthly at the quality meetings. Internal audits are completed by RNs and senior care workers with oversight from the CNM. Corrective actions are developed, implemented and signed off by the CNM when service shortfalls are identified.</p> <p>A resident and relative survey was conducted in April and May 2018. Results have been collated, analysed and reported back to residents, family and staff. The 2018 resident survey demonstrated a high level of satisfaction with the service. The annual surveys for 2019 are in progress.</p> <p>There is an implemented health and safety programme in place including policies to guide practice. Health and Safety meetings are held three times per annum and matters arising and hazard information is shared at three monthly staff meetings and monthly quality meetings. There are designated health and safety staff representatives. Hazard registers have been recently reviewed for all service areas and are easily located for staff. Staff confirmed they are kept informed on health and safety matters at meetings.</p>

		<p>Monthly trend analysis reports are posted up in staff rooms and document infection control and incident/accidents such as falls and skin tears.</p> <p>Falls prevention strategies are in place for individual residents.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service collects incident and accident data. These are collated monthly and are discussed at the staff meetings and quality meetings.</p> <p>Ten incident forms were reviewed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents. The healthcare assistants interviewed could discuss the incident reporting process. The CNM collects incident forms, investigates and reviews, and implements corrective actions as required.</p> <p>The Mother Superior and CNM interviewed could describe situations that would require reporting to relevant authorities. There has been one section 31 reported for a stage three pressure injury.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are policies to guide recruitment practices and documented job descriptions for all positions. Appropriate recruitment documentation was seen in the eight staff files reviewed (one clinical nurse manager, five healthcare assistants, one cook and one activities coordinator). Performance appraisals are current in all files reviewed. Interview with healthcare assistants informed that management are supportive and responsive.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed advised that new staff were adequately orientated to the service on employment. An education planner covers compulsory education requirements over a two-year period. Six 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 and syringe driver training and competencies. Residents and families stated that staff are knowledgeable and skilled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely,</p>	FA	<p>Sacred Heart Home and Hospital has a documented rationale for determining staffing levels and skill mixes for safe service delivery included in the rostering policy. 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 (at least two of whom are RNs) live on site and provide after-hours support as required. An activities coordinator is</p>

<p>appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>employed five days a week. Two part time activities assistants provide additional support. The rest home wing known as the villas and the hospital wing each have separate rosters.</p> <p>In the villas with 22 residents (16 hospital and 6 rest home), there is an RN on morning shift seven days a week and a second RN on two days a week on doctor days. On afternoons there is either a RN, an EN or a senior healthcare assistant. On morning shift there are three healthcare assistants (two long shifts and one six-hour shift). On afternoon shift there are two healthcare assistants (both six and a half hour shifts). When the healthcare assistant leaves at 9.30 pm, a healthcare assistant from the hospital covers until the night staff arrive.</p> <p>In the hospital wing there are 26 residents. There is an RN on every shift, every day and a second RN rostered on doctor days. The RN is supported on morning shift by six healthcare assistants (three full shifts and three short shifts). On afternoon shift there are four healthcare assistants (two short and two long shifts). On night shift there are two healthcare assistants.</p> <p>The service employs cleaners, laundry staff and kitchen staff including cooks and kitchenhands. The manager (Mother Superior) and assistant managers (sisters) each work 40 hours per week, live on site and are available to support staff as required.</p> <p>Healthcare assistants reported that staffing levels and the skill mix was appropriate and safe. Residents and family members interviewed advised that they felt there was sufficient staffing.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident's individual record. All resident records containing personal information are kept confidential. Entries were legible, dated and signed with designation by the relevant healthcare assistant or registered nurse. All files were integrated.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents have a needs assessment completed prior to entry to Sacred Heart Home and Hospital. The service has an admission policy, admission agreement and a resident information pack available for residents/families/whānau at entry. The information pack includes all relevant aspects of the service. All Sacred Heart Home and Hospital admission agreements viewed were signed. Admission agreements in the files reviewed align with contractual requirements. Exclusions from the service are included in the admission agreement. The registered nurses described the entry and admission process.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>A yellow envelope, transfer document, summary care plan and medication profile are provided when residents are transferring to hospital. All relevant information is documented and communicated to the receiving health provider or service. Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner.</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>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The hospital and rest home both have medication rooms. The medication trolleys are kept in the locked medication room.</p> <p>Registered nurses and enrolled nurses administer medications from sachets on medication rounds. These staff have been assessed for competency on an annual basis and attend annual medication education. Registered nurses attend syringe driver education. All medication is checked on delivery against the electronic medication chart. All medications were securely and appropriately stored. There were two hospital residents and one rest home resident self-medicating on the day of audit. Competency documentation was reviewed for one of the residents who was self-medicating. The medication fridge is maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening.</p> <p>Fourteen medication charts reviewed met legislative requirements; all charts had photo identification and allergies/adverse reactions noted, and 'as required' medications prescribed correctly with indications for use. Medications had been signed as administered in line with medication charts. The medication charts included three monthly GP reviews. Appropriate practice was demonstrated on the witnessed medication around.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals are prepared and cooked in the Sacred Heart Home and Hospital kitchen. The Food Control Plan is current until 20 February 2020. The chef is qualified with City and Guilds. He runs his own food safety programme for staff. 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.</p> <p>All residents have their dietary requirements/food and fluid preferences recorded on admission and updated as required. The chef maintains a folder of resident's dietary requirements that include likes/dislikes. Alternative choices are offered. The chef is informed of dietary changes and advised of</p>

		<p>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. Residents and relatives interviewed confirmed likes/dislikes are accommodated and alternative choices offered.</p> <p>Food is 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.</p> <p>A kitchen cleaning schedule was sighted. The chemicals are stored safely. The chemical supplier completes quality control checks on the sanitiser. Safety data sheets are available, and training provided as required. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves.</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>	FA	<p>If entry is declined, the management staff at Sacred Heart Home and Hospital communicate directly with the referring agencies and potential resident or family/whānau as appropriate. The reason for declining entry to the service would be if there were no beds available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The seven files sampled demonstrated that the RN completes an initial admission assessment within 24 hours which includes relevant risk assessment tools including falls risk, dietary profile, skin integrity and continence. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident/relative and significant others. All residents had interRAI assessments completed within the required timeframe. Additional assessments for management of wound care were appropriately completed according to need. The long-term care plans reflected the outcome of the assessments.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery</p>	FA	<p>The registered nurse develops the long-term support plan from information gathered over the first three weeks of admission.</p>

<p>plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>The support plans sampled reflected the outcomes of risk assessments. Interventions clearly described support required. Each resident file sampled had a risk summary incorporated into the care plan which detailed the resident's medical problems and alerts such as: risk of urinary tract infections; high falls risk. There was documented evidence of resident/relative/whānau involvement in the support planning process.</p> <p>Short-term care plans are available for use to document any changes in health needs with interventions, management and evaluations. Short-term care plans sighted included management of wounds, cellulitis, behaviour management, urinary tract infections. There was evidence that short-term care plans sampled had been evaluated at regular intervals and integrated into the long-term care plan if it was an ongoing problem.</p> <p>Medical notes and allied health professional progress notes are evident in the resident's files sampled.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The registered nurse reviews a resident's care needs when there is a change in the resident's condition. The registered nurse arranges a GP or nurse specialist visit if required. There is evidence of three-monthly medical reviews, or the GP will visit earlier if there is a change in health status. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to resident's health status. Resident files sampled recorded communication with family.</p> <p>Staff reported there are adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted.</p> <p>There were four wounds and one pressure injury being treated on the day of the audit. Wound assessments had been completed for all wounds and for the pressure injury. The GP, wound nurse specialist and district nurses are involved with clinical input for the resident with the pressure injury. One hospital resident and one rest home resident had surgical wounds. Two wounds were surgical wounds, and one hospital resident had GP input for an irregular burst haematoma. Pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.</p> <p>Behaviour management plans are developed with multi-disciplinary input and describe types of behaviour, possible triggers and interventions. The GP initiates any specialist referrals to the mental health services.</p> <p>Resident care plans (short-term and long-term) document appropriate interventions to manage clinical risk such as poor mobility, falls, skin integrity and nutrition. Healthcare assistants interviewed confirmed they are updated of any changes in residents' care or treatment during handover sessions. The active short-term care plans and long-term care plans are in the resident files.</p>

		Monitoring charts included weight, blood pressure and pulse, food and fluid intake charts.
<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>The service employs an activities coordinator who works 25 hours per week. She has many years' experience as a diversional therapist and a certificate in diversional therapy. The two activities assistants are employed Monday to Friday on a part-time basis, both team members are undertaking training in diversional therapy and building on their existing skills and qualifications. In the weekend the service facilitate activities for residents and this includes videos and concerts with visiting entertainers.</p> <p>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.</p> <p>The sisters from Little Sisters of the Poor provide ongoing spiritual and pastoral care to residents, and the on-site chapel enables residents to attend church services and communion.</p> <p>The activities programme is made available to residents in A3 format for ease of reading. The Little Sisters of the Poor also prepare a weekly 'Chatline' newsletter with activities and spiritual input. The activity programme includes exercises, crafts, housie, sing-alongs and regular weekly concerts. The activities team enable residents to access the community through bus outings. Bus outings include going to beaches and nearby attractions. The bus driver holds a current first aid certificate.</p> <p>The residents can provide feedback on the programme at the completion of each activity, through resident meetings, surveys and one-to-one interactions. The registered nurses, residents and relatives interviewed commented positively on activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Six of the seven residents' files sampled had been in the facility for longer than six months. There was evidence in these files of six-monthly evaluations of the support plan. The resident/family interviewed advised they are involved in review of their care plans. The long-term support plans reviewed evidenced that the support plan was amended with each review. Goals were reviewed and if changes were identified, the support plan reflected the changes. Short-term care plans reviewed were evaluated regularly with problems resolved or they were integrated into the long-term support plan if there was an ongoing problem.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability</p>	FA	<p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on</p>

<p>Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>resident files. A transfer document, summary care plan and medication profile are generated when residents are transferring to hospital. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and their families are kept informed of the referrals made by the service. The registered nurses interviewed described the referral process to other medical and non-medical 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>	<p>FA</p>	<p>The service has policies and procedures for the disposal of waste and hazardous material. There is an incident system for investigating, recording and reporting all incidents. The chemical supplies are kept in locked cupboards in service areas. The contracted supplier provides the chemicals, safety data sheets, wall product charts and chemical safety training as required. Approved containers are used for the safe disposal of sharps. Personal protective equipment (gloves, aprons, goggles) are readily available to staff.</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>	<p>FA</p>	<p>There is a current building warrant of fitness that expires March 2020.</p> <p>The maintenance coordinator works 30 hours per week over four days Monday to Thursday and receives calls after hours. A volunteer (retired electrician) comes in on a Friday and completes test and tagging as required. The kitchen looks after their own maintenance contractors.</p> <p>The maintenance person carries 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 has been tested and tagged. Clinical equipment is calibrated annually. Essential contractors are available after hours.</p> <p>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.</p> <p>The facility has a van available for transportation of residents with a current warrant of fitness and registration. The bus driver transporting residents has a current first aid certificate.</p> <p>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</p>

		equipment.
<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>	FA	All resident rooms have toilets and hand basins and 28 rooms have ensuites. There are adequate communal toilets and showers. The ensuites have appropriate flooring and handrails. There are vacant/occupied signs and privacy locks.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All resident rooms in the facility are of an adequate size for hospital and rest home level care. The bedrooms allow for the resident to move about the room independently or with the use of mobility aids. Residents and their families are encouraged to personalise the bedrooms as viewed. Residents interviewed confirmed their bedrooms are sufficiently spacious and they can personalise them as desired.
<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	The facility has two dining areas, multiple lounges, a chapel, a library, a recreational area with a stage, and a shop. Seating is placed appropriately to allow for groups and individuals to relax or take part in activities. The corridors are light and spacious. Residents were observed safely moving between the communal areas with the use of their mobility aids. There are communal areas for entertainment, recreation, quiet activities, dining and private meetings with family/visitors.
<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</p>	FA	All personal clothing and laundry are laundered on site. There is a laundry person rostered to work six days a week. There is a defined clean and dirty area of the laundry and an entry door and exit door. The laundry is well equipped, and the machinery is regularly serviced. Personal protective clothing is available including gloves, aprons and face masks. Adequate linen supplies were sighted. There are policies and procedures which provide guidelines regarding the safe and efficient use of laundry services. Cleaners are available daily. The cleaners' cupboard containing chemicals is locked. Cleaners' trolleys

is being provided.		are well equipped and kept in locked areas when not in use. All chemicals have manufacturer labels. Cleaning staff were observed to be wearing appropriate personal protective equipment. The environment on the day of audit was clean and tidy. There is a daily and monthly room clean schedule. The cleaning staff have completed chemical safety training.
<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>Emergency management plans are in place to ensure health, civil defence, power outages and other emergencies are covered. Fire and evacuation training has been provided. Fire drills are conducted six monthly. Flip charts covering all possible emergencies are located throughout the facility. A well-stocked emergency civil defence kit containing radios, phones torches etc is checked three monthly. There is a large diesel-powered backup generator on site which is able to provide sufficient energy to run the facility for several days. The facility is heated by a wood chip boiler with LPG backup and there is stored fuel to last several days. There is sufficient food in the kitchen to last for five days in an emergency. There are sufficient emergency supplies of stored water available on site. Appropriate training, information, and equipment for responding to emergencies is part of the orientation of new staff. External providers conduct system checks on alarms, sprinklers, and extinguishers.</p> <p>First aid supplies are available. There is a staff member on duty across 24/7 with a current first aid certificate. Call bells were appropriately situated in all communal areas.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All resident rooms and communal rooms have external windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The facility is heated and kept at a comfortable temperature. Residents and relatives interviewed confirmed the environment and the bedrooms are warm and comfortable.</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>	FA	<p>Sacred Heart has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description is available. The infection control coordinator is a registered nurse. There is a job description for the infection control coordinator with clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system. The CNM and Mother Superior are responsible for the development of the infection control programme and its review. The programme is reviewed annually. The infection control nurse provides a monthly report to the clinical</p>

scope of the service.		nurse manager and the quality team. The quality meetings include a discussion and reporting of infection control matters, trends and quality improvements. A collated report is displayed on noticeboards in the nurses' stations. Information from these meetings is communicated to the registered nurse and staff meetings.
<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>	FA	A registered nurse is the designated infection control (IC) nurse. She is new to the role and is supported by the CNM. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising staff representatives) has external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by an external contractor and have been reviewed and updated by the CNM and Mother Superior.
<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	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.

<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>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (CNM) uses the information obtained through surveillance to determine infection control activities, trends, resources, and education needs within the facility.</p> <p>An individual 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.</p> <p>Infection control data is collated monthly and outcomes and actions are reported 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.</p> <p>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.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were seven hospital residents with enablers and seven with restraint. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Enablers are voluntary. Enabler documentation for three files reviewed included consent, risk assessments, care planning, monitoring and review. Staff education on RMSP/enablers has been provided at least twice a year and on orientation of new staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>Responsibilities and accountabilities for restraint are outlined in the restraint policy and include roles and responsibilities for the restraint coordinator (RN) and approval group. A restraint approval group meets six monthly. The group includes the restraint coordinator, clinical manager, and RNs. Interviews with the staff confirmed their understanding of restraints and enablers.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (registered nurse) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p> <p>Assessments are undertaken by the restraint coordinator/RN in partnership with the resident and their family. Restraint assessments are based on information in the care plan, family, staff and GP consultation and during observations. The restraint assessment tool is completed for residents requiring an approved restraint for safety. There is provision for emergency restraint if required for safety of the residents and other residents/staff.</p> <p>Ongoing consultation with the family and staff is evident through multidisciplinary meetings and facility meetings. There were seven hospital level residents with the use of restraint as required (two using a lap belt and bedrails, three lap belt only and two bedrails only. Three restraint files reviewed included completed assessments that considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. The approval process includes ensuring the environment is appropriate and safe. Files reviewed demonstrated that assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used. The care plans reviewed also identified observations and monitoring. Restraint use is reviewed through the three-monthly assessment evaluation, three monthly restraint and six-monthly multidisciplinary meeting which includes family/whānau input. A restraint register is in place providing a record of restraint use and is completed for residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation has occurred three-monthly as part of the ongoing reassessment for the residents on the restraint register and as part of their care plan review. Evaluation timeframes are determined by risk levels. Files sampled demonstrated that appropriate evaluations are occurring.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of</p>	<p>FA</p>	<p>Individual approved restraint is reviewed at least three monthly through the restraint meeting and as part of the internal audit programme. Restraint usage is monitored regularly and is a standard agenda item at monthly quality meetings.</p>

their use of restraint.		
-------------------------	--	--

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.