

# Nazareth Care Charitable Trust - Nazareth House

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Nazareth Care Charitable Trust Board	
<b>Premises audited:</b>	Nazareth House	
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 8 September 2020	End date: 9 September 2020
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	78	

# Executive summary of the audit

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## 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

Nazareth Community of Care provides rest home and hospital level care for up to 80 residents in a modern, spacious, purpose-built facility. The service is operated by the Sisters of Nazareth as part of its Australasian operation. The Christchurch site is its only New Zealand based facility. It is managed by a general manager with responsibility for the overall operation who is supported by a clinical services manager. Residents and families were positive about the standard of care provided and the values of the organisation.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the Canterbury District Health Board (CDHB). The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, contracted allied health providers and a general practitioner.

This audit has resulted in a continuous improvement rating for the activities programme and identified areas requiring improvements relating to governance and staff orientation records.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Personal privacy, independence, individuality and dignity are supported. Staff interact with residents in a respectful manner.

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

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

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

The Clinical Services Manager with support of General Manager is responsible for management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively. Residents and families are informed about their right to complain and are supported to do so.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Nazareth Care Australasia is the organisation's governing body responsible for the service provided at this facility. Nine trustees make up the board which includes laypersons and two board members appointed from New Zealand. The general manager reports to the Australian-based chief executive officer (CEO). Strategic and business plans are documented and supported by quality and risk management processes. Systems are in place for monitoring the services provided, including regular monthly reporting to the general manager, who in turn, reports to the chief executive and governing body.

The facility is managed by an experienced and suitably qualified general manager who is a registered nurse with a background in legal and business management. A quality and risk management system is in place which includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident and family satisfaction. Collection, collation, and analysis of quality improvement data including benchmarking, is occurring, and reported to the quality and other staff meetings. Trends are identified and followed up where necessary. Meeting minutes, graphs of clinical indicators and benchmarking results are available. Adverse events are documented on accident/incident forms and seen as an opportunity for improvement. Corrective action and continuous improvement plans are developed, implemented, monitored, and signed off when completed. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated with up to date hazard registers.

A suite of policies and procedures cover the necessary areas, were current and reviewed regularly.

The human resources management policies are based on current good practice. These guide the system for recruitment, appointment, and management of staff. A comprehensive orientation and staff training programme ensures staff are competent to undertake their role. There is a systematic approach to identify, plan, facilitate and record ongoing training to support safe service delivery, including specific training in relation to Covid-19.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. There is an on-call roster of senior registered nurses.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in hard copy files or the electronic medicine management records.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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Access to Nazareth House is appropriate and efficiently managed with relevant information provided to the potential resident/family.

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

The wellbeing and lifestyle (planned activity) programme provides residents with a variety of individual and group activities and maintains their links with the community.

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

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility was purpose built in 2016 following the Christchurch earthquakes. All rooms are single with ensuite bathrooms, large bedroom spaces and with furniture including ceiling hoist options.

All building and plant complies with legislation and a current building warrant of fitness was displayed. A comprehensive preventative and reactive maintenance programme is implemented.

Communal areas are spacious which includes dining and lounge areas as well as smaller cosy spaces for residents and family use. The building is maintained at a comfortable temperature. Shaded external areas with seating are available in a large central courtyard and other outdoor spaces.

Implemented policies guide the management of waste and hazardous substances with contracts in place with waste management providers. Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen, and equipment are safely stored in dedicated area. All laundry is undertaken onsite in a well-appointed laundry. Systems used are monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of fire. Access to an emergency power source is available. Residents report a timely staff response to call bells. A contracted security company monitors the facility each night.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Four enablers and nine restraints were in use at the time of audit. Restraint is only used as a last resort when all other options have been explored. A comprehensive assessment, approval and monitoring process with regular reviews are overseen by the restraint coordinator. Enabler use is voluntary for the safety of residents in response to individual requests.

Staff receive training at orientation and thereafter every two years using and Altura online learning module. This includes all required aspects of restraint and enabler use, alternatives to restraint and dealing with difficult behaviours. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

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

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	47	0	1	1	0	0
Criteria	1	98	0	1	1	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 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation.	FA	Nazareth Community of Care has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. Staff interviewed described how they implement the rights, including open disclosure, into everyday practice. This was verified in the resident interviews and observed in practice.
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately as part of the admission agreement. Separate consent for the wellbeing and lifestyle programme, advance care planning and decisions about cardiopulmonary resuscitation (CPR) were documented on residents' files reviewed. Establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care and residents interviewed stated they were provided with enough information to give consent.

give informed consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment; although outside activities have been restricted due to the Covid-19 pandemic links have been maintained through the use of electronic media. Residents valued the links with the church community and visits from parishioners to residents who were priests or nuns were welcomed by staff.</p> <p>The facility has restricted visiting hours due to Covid-19, however, visits from residents' families and friends are encouraged when possible. Residents, and family members interviewed understood the restrictions and stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The comments and complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents in the admission pack and complaints information and forms were sighted in three key areas in the facility.</p> <p>The complaints register reviewed showed that complaints received over the past year average about one per month (12 in 2019). Appropriate actions are taken, through to an agreed resolution. All formal complaints are documented and completed within the timeframes specified in the Code as demonstrated in a sample of 2020 complaints reviewed. Action plans reviewed showed any required follow up and improvements have been made where possible. The organisation has a focus on acting on feedback from residents and family/whānau, and there are numerous examples noted where this had led to quality improvement activity.</p> <p>The Clinical Services Manager with support of General Manager is responsible for complaints management and follow up, with support from the clinical services manager. All staff interviewed confirmed a sound understanding of the complaint process, what actions they take and how this will be recorded and followed up. There were no complaints under investigation by the Health and Disability Commissioner and none recorded since the previous audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through documents included as part of the admission information provided and discussion with staff. The Code is displayed in communal areas close to the nurses' station on both floors and Health and Disability Commissioners (HDC) pamphlets together with information on advocacy services are available. Information on how to make a complaint and feedback forms are available in the main reception area.</p> <p>Residents interviewed reported being made aware of the Code, as part of the admission information pack and discussing these rights with staff. They stated they were aware of their rights, how to make a complaint and of feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were aware of the rights of the resident and observed to maintain privacy throughout the audit. All residents have a private room. Door signage is available if a resident wants privacy, does not want to be disturbed, or to have visitors. In addition to bedrooms, there are other spaces where residents and families can have private meetings.</p> <p>Residents are encouraged to maintain their independence by attending and participation in activities of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Residents interviewed confirmed that their cultural beliefs and wishes were respected and had high praise for the quality of care provided at the facility. Residents particularly valued the spiritual support provided as part of the special catholic character of the facility.</p> <p>Staff understood the service's policy on abuse and neglect and, when interviewed, discussed the process to report abuse and neglect if they were to suspect it. Education on abuse and neglect was confirmed to occur.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as</p>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health policy, developed with input from cultural advisers, to guide staff which describes the commitment to providing culturally appropriate care in partnership with Māori residents. Guidance on tikanga best practice is available. A Māori resident interviewed reported that staff acknowledged</p>

Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.		and respected their individual cultural needs.
<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>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed. Spiritual wishes are documented as part of the pastoral care and spiritual assessment completed and sighted in files reviewed. The facility philosophy is underpinned by the Sisters of Nazareth mission and residents interviewed valued the Catholic special character and the being able to attend Mass daily. One resident who leads the Rosary daily stated staff respected her wishes and work with her to be ready each morning.</p> <p>Residents are called by their preferred name as was evident in residents' files and observed during the audit. The involvement of resident and family in the development and review of care planning was documented. Feedback from the residents interviewed confirmed that their individual needs were identified, respected and were being met.</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>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. Staff professionalism is monitored through the complaints management system, resident feedback and the incident reporting and investigation process. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, speech language therapists, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. He described the staff as being clinically astute and providing a high level of care.</p> <p>Nursing staff interviewed were able to discuss where they would find best practice evidence and education online including use of Lippincott procedures for evidence-based guidelines and HealthLearn for online</p>

		<p>education. They reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included spirituality assessments and care and the resident wellbeing and lifestyle programme.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services through the DHB, although reported this was rarely required as residents speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	PA Moderate	<p>Nazareth Care Australasia is the governing body of Nazareth Community of Care through the Nazareth Care Charitable Trust. Trustees include the Sisters of Nazareth who established the Christchurch facility in 1905. The current site has been remediated following the Christchurch earthquakes in 2010/11 resulting in a state-of-the-art purpose-built facility.</p> <p>Strategic and business planning is undertaken by the board for the wider organisation. Plans sighted outlined the scope, direction and goals of the organisation which incorporates the values of the Sisters of Nazareth (love, compassion, patience, justice, respect, and hospitality). Documents reviewed described annual and longer-term objectives with associated operational planning relevant to the Christchurch facility in its business plan. The general manager (GM) provides a monthly report against the key business performance indicators to the CEO and the board of directors. A sample of reports reviewed showed adequate information to monitor performance is routinely reported including occupancy, financial performance, emerging risks, and other operational issues. The governance structure encompasses Nazareth Community of Care Australasia interests, and although there are long established governance structures in place, there is an absence of a formalised clinical governance framework to provide oversight and direction for delivering best practice care, particularly within the New Zealand health care jurisdiction. Governance and operational documentation seldom reflects the New Zealand requirements for the aged residential care environment (see criterion 1.2.1.1) and frequently only references Australian standards, guidelines, and requirements.</p> <p>The service is managed by a GM who holds relevant nursing qualifications and has a background in law and business, and management and audit of aged care facilities in New Zealand. She has been in the role for four years and is suitably skilled and experienced for the role. Responsibilities and accountabilities are clearly</p>

		<p>defined. The GM confirmed knowledge of the sector, regulatory, Ministry of Health and other mandatory reporting body requirements. She maintains currency through her professional networks including Canterbury District Health Board (CDHB), the New Zealand Aged Care Association and support from Nazareth Care Australasia. The GM is supported by the clinical services manager for the day to day operation. In addition, there is an operations and clinical risk committee which includes infection control, quality and health and safety, staff team meetings including the catering. These teams meet at differing frequency – weekly, monthly to bimonthly.</p> <p>The Nazareth Community of Care provides services under the DHB Aged Related Residential Care Agreement and currently also holds a contract with the Accident Compensation Corporation contract (ACC) for one resident. On the day of audit there were 27 rest home level residents and 51 residents receiving hospital level care. No residents were receiving end of life care or respite care at the time of audit. Hospital and rest home care is integrated across both levels of the facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the absence of the GM, the clinical services manager carries out all the required duties under delegated authority. There is ready access to the CEO based in Australia for additional guidance. During absences of key clinical staff, the clinical management is overseen by the clinical services manager or unit managers. Unit managers provide 24/7 call support for staff, including registered nurses, on a two week on/two week off basis. Staff reported these current arrangements are effective and reliable.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a quality and risk system that reflects the principles of continuous improvement and was understood by staff. This includes management of adverse events and complaints, internal audit activities, regular resident and family surveys and a separate staff satisfaction survey, monitoring of outcomes and clinical incidents including infections, falls and restraint use.</p> <p>Terms of reference and meeting minutes reviewed for 2020 confirmed adequate reporting systems and discussion occurs at meetings on quality matters. Regular review and analysis of quality indicators occurs, with benchmarking occurring with five sister facilities in Australia and, more recently, Quality Systems Party (QPS) benchmarking for aged residential care across Australasia. Samples of benchmarked clinical indicator reports indicated some comparable results and outliers. For example, recent results showed higher numbers of urinary tract infections, restraint use and falls in comparison to other benchmarked facilities. These results are under review. Information is reported and discussed at the operations and clinical risk meetings and staff</p>

		<p>meetings. Minutes reviewed included discussion on pressure injuries, restraints, falls, complaints, and other feedback received, incidents, infections, and internal audit results.</p> <p>Quality activities are monitored through software known as “Angel Trend”, with numerous examples reviewed. Staff reported their involvement in quality and risk activities through completion of a wide range of audit activities, participation in meetings and, more recently in a newly implemented online learning platform. Corrective action planning is undertaken to achieve continuous improvement, with a number of examples reviewed or completed. The organisation demonstrated a commitment to continuous quality improvement processes with the team proactively seeking opportunities for improvement and action plans put in place. Resident and family surveys are completed annually. The last survey showed a 91% satisfaction rate. Results achieved are at a consistently high level. There are examples where suggestions or comments within the resident survey have been used as improvement opportunities. A staff survey was initiated from Nazareth Care Australasia during the Covid-19 lockdown. This reflected lower staff satisfaction levels compared with the previously high levels which had been recorded.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements and were current. Primarily, the organisation uses hard copy policies which are available throughout the facility, however this is likely to change with the adoption of a new patient management system in late 2020 which includes document management. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and removal of obsolete documents. Staff are updated on new policies or changes to policies through staff meetings and meeting minutes. Some organisational documents lack reference to New Zealand standards, legislation, and regulation (see standard 1.2.1).</p> <p>The GM described the processes for the identification, monitoring and reporting of risks. The regional risk register showed consistent review and updating of risks, risk plans and the addition of new risks. Mitigation strategies were in place including for various site hazards. The health and safety officer is a personal care assistant who has attended external training in the Health and Safety at Work Act (2015) requirements. She is also proactive as part of any return to work programmes required and raising awareness of health and safety issues.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their</p>	FA	<p>Adverse and near miss events are recorded on a hard copy accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed, and actions followed-up in a timely manner. Incidents are logged into the electronic software which enables collation, analysis and trending via reports and graphs. Meeting minutes reviewed showed discussion in relation to trends, action plans and improvements made at the various committees and staff meetings.</p> <p>The Compulsory Reporting (NZ) policy describes essential notification reporting requirements. The GM advised there has been one notifications of a significant event in relation to a pressure injury made to the</p>



family/whānau of choice in an open manner.		Ministry of Health since the previous audit.
<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>	PA Low	<p>Policies and procedures, in line with good employment practice and relevant legislation, guide human resources management processes at Nazareth Community of Care. Position descriptions have been developed for all roles and those reviewed defined the key tasks and accountabilities for each role. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained. Twelve staff files were reviewed, including newly recruited staff. There is a system to ensure annual practising certificates are current.</p> <p>Staff orientation includes all necessary components relevant to the role. A staff orientation workbook has been developed and implemented for clinical staff and a number of these were reviewed. However, not all orientation workbooks had been signed off by the verifier in spite of the records showing that orientation had been fully completed. Improvement is required in relation to this (see criterion 1.2.7.4). Staff interviewed reported that the orientation process adequately prepared them for their role, and they were well supported throughout their 90-day orientation period. Non-clinical staff have a modified orientation, which covers all key requirements of their role.</p> <p>Continuing education is planned to use both on line learning and face to face sessions. This includes mandatory training topics, as required by the Aged Related Residential Care Agreement. Key competencies completed include infection control and hand hygiene, medication administration and restraint. Wound management and pressure injury training has occurred. Attendance records for group sessions are maintained and online completion certificates are filed in individual staff files.</p> <p>A high proportion of staff have completed their level three or four certificate (a total of 26 care staff), with a further 10 holding the level 2 National Certificate in Health and Wellbeing to meet the requirements of the provider's agreement with the DHB. A further six staff are about to commence the programme. Nine registered and enrolled nurses are interRAI trained and a further two staff are undergoing training.</p> <p>Annual performance appraisals are undertaken for all staff groups. Those reviewed were current. Staff reported that the annual performance appraisal provides an opportunity to discuss individual training needs or where additional support may be required.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely,</p>	FA	<p>There is a documented rationale (updated in 2019) for determining staffing levels and skill mixes in order to provide safe service delivery. The GM reports that acuity is managed effectively by ensuring that levels of care are maintained at approximately 50 hospital level and 30 rest home level care residents. The set rosters</p>

appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		<p>reviewed show appropriate skill mixes are maintained over all shifts. Nazareth Community of Care has a contract with a nursing bureau to fill any short notice roster gaps.</p> <p>The facility adjusts staffing levels to meet the changing needs of residents. An additional flexible shift can be added (float shift) if needed (eg, when there is a new complex resident admitted to the facility – this is currently in place for morning shift). The minimum number of staff is provided during the night shift and consists of a registered nurse and two caregivers on each level. An early start shift is designed to assist residents who wish to attend mass at 10am to do so. Afterhours, two unit managers share two weeks on/two weeks off call rotation. Care staff interviewed reported adequate staff were available and that they were able to complete the work allocated to them. This was also supported by residents and family/whānau interviewed. Observations and review of the weekly roster cycle sampled (current and projected) confirmed adequate staff cover is planned and provided. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24/7) registered nurse cover on both levels in the facility.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current, comprehensive and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. All resident records reviewed contained the resident's unique identifier, the NHI. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from family and the resident's GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</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>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of resident information to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes.</p> <p>The hospital level care resident used in tracer methodology was transferred to an acute hospital during the audit. Documentation was comprehensive and transfer information was informative. The wife of the resident reported being kept well informed during the transfer of their relative.</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>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage including the management of subcutaneous medications using syringe drivers.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The registered nurse checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required and was evident in the charts reviewed.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used. Allergies and sensitivities are clearly recorded on the resident's file and on their medication chart</p> <p>No residents were self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner and the registered nurse interviewed was able to describe the process to be followed, including resident assessment, education and medication storage should this occur.</p> <p>There is an implemented process for reporting of any medication errors. Review of records confirmed this process is followed, medication errors are investigated and there is follow up with staff involved.</p>

<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a qualified cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Christchurch City Council. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The catering manager and kitchen assistants have completed relevant safe food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed; this is updated as the resident's needs change. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> <p>Resident satisfaction with meals was very high with food being described as excellent; this was verified by resident and family interviews. The catering manager stated he understood the importance of food and meal service in the lives of the residents and this is evidenced in the standard of service provided.</p>
<p><b>Standard 1.3.2: Declining Referral/Entry To Services</b></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 a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and</p>	FA	<p>Information is documented using a suite of validated assessment tools as referred to above to identify any deficits and to inform care planning. Care plan are based on the assessed need and included outcome goals and interventions based on the resident's wishes. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and families confirmed their</p>

preferences are gathered and recorded in a timely manner.		involvement in the assessment process.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, wellbeing and lifestyle (activities) notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Policy states that caring for, acknowledging, and understanding individual needs is central to the Nazareth Way. Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	CI	<p>The activities programme known as the wellbeing and lifestyle programme is a strength of the service. It is provided by a trained diversional therapist holding the national Certificate in Diversional Therapy supported by an assistant who is undertaking diversional therapy training and volunteers. All staff understand the importance of the programme to the lives of residents. There is integration with the provision of spiritual care, the church and the Sisters of Mercy who are an integral part of Nazareth House.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated on admission and as part of the formal six monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities, such as a recent market day. Facilities include rooms for small gatherings, a larger activities room and a cinema. Individual, group activities and regular events are offered, a register of attendance is kept and reviewed to</p>

		<p>monitor the popularity of activities. Puzzles, board games and books are available for residents' use. Residents and families are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme varied and interesting. Examples are given where the wellbeing and lifestyle programme is making a significant difference to residents' lives. This area is rated as continuous improvement (CI).</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is evaluated on each shift and reported in the progress notes. Progress notes provide a detailed evaluation of actions taken and progress towards individualised and personalised goals. If any change is noted, it is reported to the registered nurse.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, and pressure injuries. When necessary, and for unresolved problems, long term care plans are added to and updated. This was evident in resident files reviewed. Residents and families interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or registered nurse sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including internal referrals to the pressure injury link nurse and external referral to speech language therapist for assessment of swallowing. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews.</p> <p>Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. On the day of audit one resident was transferred to the public hospital. Comprehensive resident information was sent with the resident and, when interviewed, his wife said she had been kept informed.</p>
<p>Standard 1.4.1: Management Of Waste</p>	FA	<p>Documented processes for the management of waste and hazardous substances were in place. There is a current hazardous substances policy. No hazardous chemicals were stored on site which required a</p>

<p>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>hazardous chemical rating for the quantity on hand.</p> <p>Cleaning chemicals are stored and refilled in designated cleaners' rooms in each wing. These are locked with restricted swipe access. Commercial products are in labelled containers. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training with these records noted in staff files. Cleaning trolleys have locked cupboards for storing any cleaning products in use. Material safety data sheets are available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. Any related incidents are reported in a timely manner.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this, including gloves, plastic aprons, and eye protection.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expires October 2020) was publicly displayed in the entry.</p> <p>Appropriate systems were in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. The testing and tagging of equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Nazareth Community of Care has excellent maintenance support, with contracts with local external providers to maintain the wide range of equipment in use, including building maintenance system monitoring, the generator, water systems and lifts. Hot water temperatures are managed via the building maintenance systems, but also randomly checked each month at the tap (records sighted and in the correct range).</p> <p>External areas are safely maintained and were appropriate to the resident groups and setting. The environment was conducive to the range of activities undertaken in the areas, including a large internal courtyard with shading and a raised stage area and seating. The environment was hazard free, with wider than average hallways and residents were safe. Residents interviewed confirmed they know the processes they should follow if any repairs or maintenance are required and that any requests are appropriately actioned. A maintenance book is available for each wing and this was signed off when the repairs or maintenance is completed.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate</p>	FA	<p>All eighty residents' rooms have their own spacious ensuite. A separate bathroom with an accessible Parker bath is available in each wing. There are adequate numbers of accessible bathrooms and toilets throughout the facility, including near activity, dining and lounge areas. There are 10 wheelchair accessible public toilets throughout the building plus visitor toilets (two in each wing). Appropriately secured and approved handrails are provided in the toilet/shower areas and ensuites, and other equipment/accessories are available to</p>

toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		promote residents' independence.
<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	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation in larger rooms (29sq metres), with some built in furniture and display shelves for personal items. Rooms are personalised with furnishings, photos and other personal items displayed. Bedrooms all have the ability to add a ceiling hoist to the already fitted track if required.</p> <p>There is room to store mobility aids walking frames and wheelchairs. Staff and residents reported the adequacy and convenience of the bedrooms. Mobility scooters are stored and charged appropriately and did not impede walkways or create a hazard for mobile residents.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities and relaxation. The dining and lounge areas are spacious and enable easy access for residents and staff. There is a café area adjacent to the entrance and large chapel, enabling residents to socialise after mass each morning. Residents can access areas for privacy such as small 'Breakout' lounges and a small kitchen in each wing, if required. Furniture is appropriate to the setting and residents' needs. It is arranged in a manner which enables residents to mobilise freely.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is undertaken on site in a dedicated laundry using commercial washers and dryers. Resident's personal items are laundered on site or by family members if requested. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. A labelling service is available. The laundry is currently operated by trained laundry staff, who demonstrated a sound knowledge of the laundry processes, dirty/clean flow, and handling of soiled linen.</p> <p>There is a small designated cleaning team who have received appropriate training, including an infection control update in relation to Covid-19. An interview of cleaning staff and training records indicated that staff are aware of the correct processes, use of cleaning products, additional cleaning of high touch areas.</p>



		Chemicals are stored in a locked cleaners' cupboards in the wings and in correctly labelled containers (see also comments in standard 1.4.1). Spot cleaning of carpets can be undertaken with on-site equipment; however, larger carpet cleaning tasks are contracted out. Cleaning and laundry processes are monitored through the internal audit programme. Observation of the environment indicated a high standard of cleaning was maintained throughout.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Information is provided to new staff as part of the orientation programme. Disaster and civil defence planning guidance is available should there be a disaster. This includes the procedures to be followed in the event of a fire or other emergency.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 4 November 2016. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 10 February 2020. The orientation programme includes fire and security training with ongoing training included in the Altura on line modules. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, include food, water, blankets, torches, and batteries, meet the requirements for eighty residents. A civil defence kit "wheelie bin" with the essentials is located in each wing and the contents checked three monthly. There is an 8000 litre water storage tanks located around the complex, and a groundwater well is available on site for non-potable water. Emergency lighting is regularly tested. A standby generator can run 24 hours over seven days at full load and is maintained and regularly tested, including blackout testing. The facility is well prepared for emergencies including earthquakes following the rebuild subsequent to the Christchurch earthquakes in 2010/11. First Aid supplies are located on each level in the medical room, with a contractor first aid kit held at reception.</p> <p>Call bells alert staff to residents requiring assistance. These silently alert to a screen in the wings and DECT phone system carried by staff. Call system audits are completed on a regular basis. Few concerns have been raised about response times, with most residents stated they are satisfied that staff are "pretty good".</p> <p>Appropriate security arrangements are in place, with an external company providing on site checks overnight. The external gates, doors and windows are locked automatically at a predetermined time. There is closed circuit TV monitoring located at the nurses' station which external entrances and service corridor. Residents are made aware of this on admission.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	FA	<p>All residents' rooms and communal areas have opening external windows. There are external opening doors to access the large courtyard.</p> <p>A boiler heating system fuelled by wood pellets provides an automatically adjusted heating at set</p>

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		temperatures as well as heaters in each room. Heating is controlled through the computerised building management system. A feature gas fire is located in the “marketplace” area of the facility and was observed to be enjoyed by both residents and family members. The facility was warm and well ventilated.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the DHB clinical nurse specialist for infection prevention and control. The infection control programme and manual are reviewed annually.</p> <p>The unit manager who is a registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in policy. Infection control matters, including surveillance results, are reported monthly to the clinical service manager, and tabled at the quality, health and safety and IPC committee meeting. This committee includes the general manager, clinical service manager, unit managers, IPC coordinator, the health and safety representative, and representatives from food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. As a result of the Covid-19 pandemic extra signage has been placed at the entrance to the facility and electronic sign in for visitors now includes a health declaration.</p> <p>An outbreak management group was convened in response to the Covid-19 threat. Meeting minutes sighted showed appropriate planning for a possible outbreak was in place.</p> <p>Staff are encouraged to have a seasonal flu vaccine which is provided by Nazareth House.</p> <p>The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell and staff are required to sign a Covid-19 health declaration at the start of each shift. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and</p>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for nine months. She has undertaken online education in infection prevention and control, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. PPE stocks, outbreak management signage and supplies were sighted during the audit. These have</p>

meet the needs of the organisation.		been audited by the DHB and found to be sufficient.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in June 2020 and include appropriate references. Information for staff on the prevention and management of Covid-19 has been prepared and communicated.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided online, by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this occurred due to a respiratory outbreak in January 2020 when education on hand hygiene and outbreak management was carried out.</p> <p>Additional education has occurred in preparedness for a possible Covid-19 outbreak, this included donning and doffing of PPE, hand hygiene and information on the facility's pandemic plan and outbreak management.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and isolation practices.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required</p>

carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		<p>management plan are discussed at handover, to ensure early intervention occurs. This was verified by observation, interview and review of residents' files.</p> <p>Monthly surveillance data is collated and reported to the quality, health and safety and IPC meeting. Data is reviewed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via meeting minutes. Graphs are produced that identify trends for the current year and are displayed for staff. Data is benchmarked externally through QPS.</p> <p>A summary report for a recent respiratory infection outbreak was reviewed and demonstrated a thorough process for reporting and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator, who is a registered nurse, provides support and oversight for enabler and restraint management in the facility. She demonstrated a sound understanding of the required processes and her role and responsibilities.</p> <p>On the day of audit, nine residents were using restraints and four residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. This provides for a robust process which ensures the on-going safety and wellbeing of the resident.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, the restraint register, review of four files of residents using approved restraints and from interviews with the restraint coordinator and 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</p>	FA	<p>The restraint approval group consists of the restraint coordinator (registered nurse), care services manager and the well-being and lifestyle coordinator, and is responsible for the approval of restraint use and the restraint processes, as defined in the restraint policy. It was evident from review of meeting minutes, review of residents' files and interview with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored, reported and analysed. Restraints approved for use include bedrails, chair tables, princess chair, lap belts and chair brief.</p> <p>Evidence of family/whānau/EPOA involvement was noted for restraint and enabler use, with one record sampled including consent from the resident's EPOA as they were unable to physically sign the document. Restraint and enabler use are included in the care planning process (including an initial care plan), following assessment.</p>

known to service providers and others.		
<p><b>Standard 2.2.2: Assessment</b></p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint was documented in four of four files reviewed and included all requirements of the Standard. The initial assessment was undertaken by a registered nurse with the restraint coordinator's involvement, and input from the resident's family/whanau/EPOA. The RN restraint coordinator described the documented process. The general practitioner has been involved in the final decision on the safety of the use of the restraint, with evidence of this on each file reviewed. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives to use of restraint and the likely risks. The desired outcome was to ensure the residents' safety and security. Completed assessments were sighted in the records of residents who were using a restraint. Any episode of restraint or an enabler use is reviewed within the first 24-hours of initial implementation.</p>
<p><b>Standard 2.2.3: Safe Restraint Use</b></p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members. Time is spent explaining how the resident can be safely supported and suitable alternatives, such as the use of sensor mats, low beds, intentional rounding, one to one staff input as part of a 24 hour diversional plan or a mattress on the floor are explored before use of a restraint is implemented. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Monitoring timeframe are specified according to the level of risk identified. Records contained the necessary details including when in use and when the resident is released from restraint and their need for exercise, food, fluids, and toileting. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. This was included in the resident's care plan and progress notes.</p> <p>A restraint register is maintained, updated every month by the restraint coordinator and three monthly at the scheduled GP visit. All restraints are reviewed at the annual approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours through the on line learning platform introduced since the previous audit. Staff spoken to understood safe restraint use and efforts to minimise their use, that the use of restraints is to be minimised and how to maintain safe use.</p>
<p><b>Standard 2.2.4: Evaluation</b></p> <p>Services evaluate all</p>	FA	<p>Review of residents' files evidenced the individual use of restraints is reviewed and signed off monthly by the restraint coordinator and evaluated during care plan reviews three monthly and interRAI reviews every six</p>

episodes of restraint.		<p>months, regular restraint evaluations and at the annual restraint approval group meetings.</p> <p>The evaluation includes all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Restraint monitoring and quality review is undertaken by the restraint approval group and considers all restraint practice. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and as well as any feedback from the doctor, staff and families.</p> <p>Restraint use is reported to the operations and clinical risk group each month as part of a set agenda. Any changes to policies, guidelines, education, and processes are implemented if indicated. Data reviewed, minutes and interviews with the restraint coordinator and personal care assistants confirmed that the use of restraint is reviewed, however a reduction in the use of restraint cannot presently be demonstrated, with types and numbers of restraint similar to that recorded in 2019.</p>

## 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)
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	<p>PA</p> <p>Moderate</p>	<p>Nazareth Community of Care has a governance structure encompassing its Australasian interests, with the NZ GM reporting to the CEO based in Australia. The structures are well defined and includes two current organisational charts (one for Australasia and one for the NZ operation). This reflects reporting requirements, up to and including the Board. Documentation relevant to the Nazareth Community of Care Australasia has been developed including clinical services specific to the New Zealand setting. However, there are a number of examples where key organisational documents do not reflect the differences in requirements in the two jurisdictions, with the only references being to Australian standards and requirements. Additionally, there is limited clinical governance structures to support the NZ operation.</p>	<p>Finding:</p> <p>There is an absence of a formalised clinical governance framework to provide the oversight and direction necessary for best practice service delivery and the partnership model in the NZ</p>	<p>Develop structures, processes and documentation which ensures Nazareth Community of Care Australasia has appropriate systems to support its services in the two jurisdictions.</p> <p>90 days</p>

			<p>jurisdiction.</p> <p>Documentation has been developed which covers the needs of the organisation as a whole but does not always reflect the NZ requirements and standards in the Aged Care environment.</p>	
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	<p>There is a comprehensive orientation workbook developed for clinical staff to complete in the first 90 days of employment. Files sampled and reviewed (four of four staff employed less than six months) indicated that the workbook was not consistently signed off to indicate clinical competency components have been achieved. In two examples, the 90-day appraisal had been stated as completed without the workbook being fully completed and signed off as required.</p>	<p>There is inconsistencies in the sign off of the orientation workbook at the end of the clinical staff orientation period.</p>	<p>Establish processes which ensure that orientation workbooks content is fully completed prior to sign off of the programme.</p> <p>180 days</p>



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

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	<p>Activities, provided as part of the wellbeing and lifestyle programme, are meaningful and imaginative. They are aimed to improve the lives of the up to 80 residents who call Nazareth House home. The programme is well planned and varied, and includes activities aimed to maintain physical and mental abilities as well as meet social needs and interests. Regular activities include exercise classes, bowls, mini golf, happy hour, craft and knitting groups, baking, housie, movies, visiting pets and entertainers. Individual one to one activities are provided for residents who do not attend groups. Activities are evaluated monthly with residents and the programme updated. Newsletters for residents and families, as well as an activities timetable, keeps residents informed of changes.</p> <p>A high number of residents attend Mass daily, a resident leads the Rosary daily and a Holy hour allows for prayer and reflection. It was identified that residents who wished to</p>	<p>Nazareth House has implemented an activities programme that is meaningful and varied for the residents. The programme allows residents to maintain strengths and skills, maintain connections with the community and experience events they could otherwise not access. As examples this has included, quality improvements to enable residents to attend Mass daily, holding a community engagement Market Day, a virtual trip to England and specific men only events for male residents in addition to an extensive regular programme of events. The depth and breadth of activities seen in the Nazareth House wellbeing and lifestyle programme exceeds that expected for full attainment of this criteria.</p>

		<p>attend the daily Mass became upset when they were not able to be moved to the Church in a timely manner. A quality improvement project aimed to reduce delays for residents established a transfer assistance role. This has reduced waiting time and has reduced residents' anxiety. Evaluation showed increased resident satisfaction with the process. Non-Catholics seeking solitude may attend the Church outside of Mass times.</p> <p>Special events reviewed and discussed on site include the following:</p> <ol style="list-style-type: none"> <li>1. A Market Day with a French theme aimed to involve residents with the community and include family and friends. Residents were involved in preparations and those interviewed described making jam, knitting hats and baking to be sold in addition to the outside stall holders. One resident who was part of the knitting group described the process as giving her a purpose and has continued knitting in preparation for the next event.</li> <li>2. Come fly with me. A virtual trip to England to see the Queen was held to give residents the experience of travel. The large activities room was transformed into an aircraft and residents issued with boarding passes. Volunteer Air New Zealand staff, a Captain and two air stewardesses, video/audio effects and drinks served from a trolley gave authenticity to the event. On arrival residents were able to have their photograph taken with the Queen and Prince Phillip (two residents dressed up). The event concluded with Air New Zealand lollies for those residents who had been assessed as appropriate to receive them. Residents interviewed continue to speak highly of this event and it was noted how their eyes lit up in memory of the 'trip'.</li> <li>3. Burgers and Beers. Activities are provided for specific groups and an example of this was the men only Burgers and Beers lunch to celebrate Father's Day 2020. The facility has a predominantly female staff and the male residents interviewed valued having time in a male only environment.</li> </ol>	
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		4. COVID-19 communications between residents and families. Due to the current pandemic visiting has been restricted. The wellbeing and lifestyle coordinator has enabled residents to connect with families through electronic media such as skype to allow residents to connect with family. This was valued by both residents and families.	
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End of the report.