

Henrikwest Management Limited - Catherine Lodge Retirement Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Henrikwest Management Limited

Premises audited: Catherine Lodge Retirement Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 23 February 2021 End date: 24 February 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 28



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

Catherine Lodge Retirement Home provides rest home level care for up to 35 residents. The service is operated by Henrikwest Management Limited and managed by a facility manager and a registered nurse. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family, managers and staff and a general practitioner.

The audit has resulted in four continuous improvement ratings; one in relation to complaints management, three related to quality and risk management, and one in relation to adverse event reporting. No new areas were identified as requiring improvement.

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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Resident and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

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

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 residents' needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Henrikwest Management Limited is the governing body and is responsible for the service provided at this facility. A business plan and quality and risk management plans are documented and include the scope, direction, goals, values and mission statement of the organisation. Robust systems are in place for monitoring the services provided including regular daily, weekly and monthly reporting by the facility manager to the governing body. Catherine Lodge Retirement Home is one of three aged care services owned by the same organisation. The facility is managed by an experienced and suitably qualified manager who is an enrolled nurse.

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, family and staff satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings, with discussion of trends and follow up where applicable. Meeting minutes, graphs of clinical indicators and benchmarking results are available and were being reviewed. Corrective action 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 and the hazard register was current and up-to-date.

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

The human resources management policies, based on current good practice, guides the system for recruitment and appointment of staff. A comprehensive orientation/induction and staff training programme ensures staff are competent to undertake their role. A systematic approach to identify, plan, facilitate and record ongoing training supports safe service delivery, and includes regular individual performance review.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents are met. There is an on-call after-hours system in place.

Resident's information is accurately recorded, securely stored and is not accessible to unauthorised people. All records are up to date, legible and relevant residents' records are maintained in using an integrated hard copy record.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

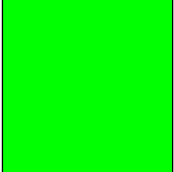
The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and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

The planned activity programme provides residents with a variety of individual and group activities 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 has been purpose built. All rooms are single, with the exception of one double room, with some having ensuite bathrooms. All rooms are of an adequate size to provide personal cares.

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

Communal areas are spacious and maintained at a comfortable temperature. Shaded external areas in two locations are available with appropriate seating for residents.

Implemented policies and procedures guide the management of waste and hazardous substances. Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is undertaken onsite with systems monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular six-monthly fire drills are completed and there is a sprinkler system and call points installed in case of fire. Emergency lighting is available and is checked monthly. Emergency stores are available. Residents reported a timely staff response to the nurse call system in place. Security is managed effectively onsite.

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. No enablers and no restraints were in use at the time of audit. Restraint is only used as a last resort when all other options have been explored. Enabler use is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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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	0	45	0	0	0	0	0
Criteria	4	89	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>Catherine Lodge Retirement Home 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 were observed calling residents by their preferred name.</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>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent was defined and documented, as relevant, in the residents' records. Staff were observed to gain consent for day-to-day care.</p>

<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>	<p>FA</p>	<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>	<p>FA</p>	<p>Residents are encouraged to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment events in the community.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Even though there were visitors' restrictions recently due to the pandemic, residents and family members interviewed stated they felt comfortable about the way it was managed and were kept well informed.</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>	<p>FA</p>	<p>The complaints policy (reviewed 24 July 2019) and associated forms meet the requirement of Right 10 of the Code. There is also a flow chart developed and implemented to guide staff. The complaints information is provided to residents on admission and there is complaint information and forms at reception. A complaints/compliments box is also located in the reception area of the facility.</p> <p>The complaints register reviewed evidenced 42 minor complaints and one serious complaint (facility level complaint) over the past year and that actions were taken through to an agreed resolution, were fully documented and completed within the required timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible. No complaints from external agencies have been received.</p> <p>The facility manager is responsible for complaints management and follow up. The facility manager has significantly improved the complaints process and provided an annual summary and comparative study of improvements from the previous year and a continuous improvement has been awarded for complaints management.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission information provided and discussion with staff. The Code is displayed in common areas, together with information on advocacy services, how to make a complaint and 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>	<p>FA</p>	<p>Residents and families of Catherine Lodge Retirement Home (Catherine Lodge) confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed to maintain privacy throughout the audit. Most residents have a private room.</p> <p>Residents are encouraged to maintain their independence by community activities, arranging their own visits to the doctor and going on regular outings. 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>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</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>	<p>FA</p>	<p>A staff member at Catherine Lodge at the time of audit identify as Maori. Staff understands Maori 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 plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally</p>	<p>FA</p>	<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. The resident satisfaction survey confirmed that individual needs are being met.</p>

safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	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. All registered nurses have records of completion of the required training on professional boundaries. 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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	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, diabetes nurse specialist, wound care specialist 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. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their/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 supported 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. Staff know how to access interpreter services, although reported this was rarely required due to staff able to provide interpretation as and when needed and the use of family members.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and	FA	There is a generic business, quality and management plan for 2021 that is documented for Catherine Lodge. A quality policy statement is in place. A mission statement and the organisation's philosophy are clearly documented. Quality and risk planning is clearly documented with goals and objectives covering consumer focus, provision of effective programmes, certification and contractual requirements, quality and risk management and continuous improvement. These identify how each goal will be met, who is

<p>appropriate to the needs of consumers.</p>		<p>responsible and how they are evaluated. The organisation's mission statement and philosophy are also identified in the quality plan. The facility manager reports to the general manager everyday Monday to Friday on any concerns or issues that may have arisen. Staff on in the weekend inform the facility manager of any emerging risks or issues as required.</p> <p>The service is managed by a facility manager who holds relevant qualifications in healthcare and is an enrolled nurse and has been in this role for 14 years and has worked in the aged care sector for thirty years. The facility manager is suitably skilled and experienced for the role and the responsibilities and accountabilities as defined in the job description reviewed. At interview, the facility manager confirmed comprehensive knowledge of the aged care sector, regulatory and reporting requirements and maintains currency through ongoing management and nursing education as per the training records. The facility manager is well supported by a regional manager, financial manager, owner directors and the general manager.</p> <p>The service holds contracts with the DHB for rest home level care, rest home level care - long term support chronic health (LTSCH) and individual treatment bed mental health – MHFF0001). On the day of audit 27 residents are receiving rest home level care and one resident is under the individual treatment bed mental health contract.</p> <p>A resident granted a dispensation from the Ministry of Health HealthCERT to receive hospital level cares at Catherine Lodge is no longer receiving this service as from the 23 November 2020.</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>The facility manager manages the day-to-day operation of the service. When absent from the facility, the registered nurse continues to provide clinical input and the regional manager who has worked at this facility for 14 years covers the facility. The regional manager covers three of the organisation's facilities and understands the sector and is able to carry out all the required duties under delegated authority. The general manager is available to support the regional manager and registered nurse as required.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk</p>	<p>FA</p>	<p>Staff are made aware of the business and quality plans and those interviewed had a good understanding of the processes in place. The quality and risk system in place reflects the principles of continuous improvement. This includes the management of audit activities including regular resident/staff and family satisfaction surveys, monitoring of outcomes, clinical incidents including infection prevention and control management.</p>

<p>management system that reflects continuous quality improvement principles.</p>		<p>The organisation acknowledges the Health and Safety at Work Act 2015 and ensures all requirements are met and adherence to safety procedures and practices as set out by Catherine Lodge. Employees are to conduct themselves in a manner that avoids harm to themselves and others. The health and safety committee exists for the purpose of implementing, maintaining and monitoring a safety programme for residents, staff and visitors to the facility. Staff input is encouraged. There is a designated health and safety coordinator whose authority and accountability for safety related matters is clearly defined.</p> <p>Hazards are identified and documented. The facility manager described the identification, monitoring and reporting of any risks and the development of mitigation strategies. The risk register is reviewed at least annually. New risks are added to the register following a documented process. The register was current and up to date. There are detailed procedures to show that health and safety is managed to meet the legislative requirements.</p> <p>Terms of reference and meeting minutes reviewed confirmed efficient reporting occurs, action is taken and compared to the previous year and for benchmarking purposes. Regular review and analysis occurs, and related information is reported monthly and discussed at the quality and staff meetings. Minutes maintained were available for review. Discussion occurs on pressure injuries (if any), restraints, falls, complaints, adverse events, infections, wounds, audit results and activities programme.</p> <p>Staff interviewed stated they were involved in quality and risk activities through participating in the internal audits. Corrective action sheets are developed and implemented to a high standard and demonstrated a continuous process of quality improvement is occurring. The service has gained three continuous improvement ratings relating to quality and risk management at Catherine Lodge.</p> <p>Annual surveys, such as the staff wellness survey, completed in May 2020 (outcome score was 96.4%) with positive comments. A resident satisfaction survey was completed 30 June 2020 and was signed off by the general manager. In the family survey completed 14 July 2020 (families were very satisfied overall with services provided). All outcomes of surveys and internal audits were compared with the previous year's outcomes and a summary was completed with any recommendations. If they were any actions to be taken, the person responsible was identified and actions were signed off when completed, and dated. Quality improvement was discussed at the staff meeting.</p> <p>Policies and procedures reviewed cover all aspects of the service. Documents are managed appropriately and stored for retrieval processes if needed.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	<p>FA</p>	<p>Staff document adverse events and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed up in a timely manner. Adverse event data is collated, analysed and reported to staff at the staff/quality meetings and review showed discussion in relation to any trends identified, action plans</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>in place and any improvements made. The process undertaken by the facility manager far exceeds the normal expectations and a continuous quality improvement has been raised for adverse event reporting.</p> <p>Policy and procedures described essential notification reporting requirements. There has been one Section 31 notice completed since the previous audit to HealthCERT. The facility manager and registered nurse are fully informed of what agencies to report to when a serious event occurs. The one case was for a hospital level resident with a dispensation to be cared for at this facility. The resident was admitted with a grade 4 pressure injury which was reported on the incident form. The resident was managed well with a multidisciplinary approach including input from the DHB wound care specialist nurse, general practitioner, registered nurse and the palliative care team at the time.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Policies and procedures reviewed were in line with good employment practice and relevant legislation and guide human resources management processes. Job descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates, where applicable. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support from a 'buddy' through their initial orientation period. Most staff interviewed had been at the facility for some years. Staff records reviewed show documentation of completed orientation and a performance review (appraisal) is completed annually.</p> <p>Continual education is planned on an annual basis. Mandatory training requirements are defined and scheduled to occur over the course of the year. All care staff have either completed or have commenced a New Zealand Qualifications Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. The regional manager is responsible for the staff records and was interviewed. Of a total of 14 care staff (healthcare assistants), six care staff have completed NZQA level four and five have completed level three qualifications. Three cleaners have completed level 2. One cleaner has a dual role of being a cleaner and a caregiver. Two new staff are enrolled for 2021. Appraisals were current for all staff. All staff have completed and have current first aid certificates. Annual staff competencies were completed and all senior care staff who administer medicines have completed annual medicine competencies which were recorded.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The facility adjusts staffing levels to meet the changing needs of the residents. The minimum number of staff is provided during the night shift and consists of two HCAs. An after-hours on call</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>roster is in place, with staff reporting that good access to advice is available when needed.</p> <p>Care staff reported adequate staff were available and that they were able to complete the work allocated to them. This was further supported by residents and family interviewed. Observations and review of a six-week roster cycle sampled during this audit confirmed adequate staff cover has been provided. At least one staff member on a shift has a current first aid certificate.</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>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. 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>	<p>FA</p>	<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 the NASC service and the GP for residents accessing respite care.</p> <p>Family members and residents 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>On the day of audit there were 28 residents receiving long term care.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or</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 residents to and from acute care services. There is open communication between all services, the resident and the family/whanau. 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. A family member interviewed reported being kept well informed during the transfer of their relative.</p>

transfer from services.		
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>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. Regular medication audits are completed and are followed with appropriate corrective actions. There was evidence of pharmacy involvement. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates.</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>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There were no residents who were self-administering medications at the time of audit. Staff understand the processes on self-administration of medication, should it be required.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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>	FA	<p>The food service is provided on site by a kitchen team consisting of two cooks 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 in August 2019. 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 Auckland Council effective from 16/01/2020. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification.</p>

		<p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. 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>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 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 with registered nurses (RN) and facility manager (FM). There is a clause in the access agreement related to when a resident's placement can be terminated.</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>On admission, residents are assessed to develop initial care plan. Within three weeks of admission a comprehensive assessment is completed using nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening, depression scale and interRAI, as a means to identify any deficits and to inform long term care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by a trained interRAI assessor on site.</p>
<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, 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</p>	FA	<p>Documentation, observations and interviews verified that the care provided to residents was consistent</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>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 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 level 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>	<p>FA</p>	<p>The activities programme is provided by a trained diversional therapist holding the national Certificate in Diversional Therapy. A wide range of activities are provided seven days a week.</p> <p>A social assessment and history is 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 and as part of the formal six monthly care plan review.</p> <p>The weekly activities planner sighted matched the skills, likes, dislikes and interests identified in the assessments. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they enjoy the programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</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 skin tears, fall risk, eye pain, and bruising. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau 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</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a contracted GP service, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the eye clinic, mental health for older people, and the dermatology clinic. The resident and the family/whānau are</p>

<p>or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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>Documented processes for the management of waste and hazardous substances were in place. A contracted service is responsible for collecting waste at timeframes that are pre-arranged. The council collects recycled waste every Monday. The hazardous substance register was sighted and reviewed and updated last on 21 January 2021. This is signed off by the general manager (GM). The hazard register covers all chemical used at this facility, care provision hazards, outside the premises hazards, laundry and cleaning hazards and any kitchen hazards.</p> <p>The doors to the areas storing chemicals were secured and containers labelled. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew how to access information if needed. A spills kit is available should an event occur. Any related incidents are reported in a timely manner.</p> <p>There is adequate provision and availability of personal protective clothing and equipment (PPE) and staff were observed using this including gloves, goggles, masks and gowns as needed. The regional manager is responsible for ensuring adequate stocks of PPE are ordered and available for staff at all times. A cupboard is available with stores of PPE resources for use in the event of an infection pandemic.</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>A building warrant of fitness expires 28 September 2021 is publicly displayed. Appropriate systems are 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 is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Significant improvements have been made to the inside of the facility and to the outside since the previous audit including a new roof for the building. Catherine Lodge has been totally re-carpeted and painted with a modern colour scheme throughout. All furniture has been recovered and a new call system has been installed throughout all service areas and individual resident's rooms.</p> <p>External areas are fully maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the designated areas. The environment was hazard free and residents were. Residents interviewed confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they were happy</p>

		with the environment.
<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	<p>There is a mix of toilet, showers and bathing facilities. There are eight toilets, eight separate showers and fifteen rooms have their own ensuite bathrooms. There are adequate numbers of accessible bathrooms and toilets throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Staff and visitor toilets are available. There is also a shower for staff to use, when pandemic planning is in place.</p>
<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>There are thirty-five (35) individual residents' rooms including one double room. There is only one resident in this room currently. Adequate personal space is provided to allow residents and staff to move around freely within their bedrooms safely. Where rooms are shared approval would be sought. Rooms are personalised with ornaments, photographs and other personal items displayed. There is adequate space to store mobility aides, walking frames, a hoist and wheelchairs. Staff and residents reported adequacy of individual bedrooms.</p> <p>On visual inspection all furniture is provided which includes a built-in vanity wardrobe and drawers, a bedside cabinet, a separate chest of drawers, an armchair and a visitor's chair. A wall mounted heater which is located at a good height to put on/off as needed. The bed has a headboard attached which extends at the head of the bed and around the back wall and is fixed to the bed for safety reasons.</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>There are communal areas available for residents to engage in activities. The main lounge and dining areas are spacious and enable easy access for residents and staff. A large screen television is available in the main lounge and comfortable seating. Residents are able to access areas for privacy if required as there are three small lounge areas for family/whanau and residents to enjoy. Furniture is appropriate to the setting and residents' needs. It is arranged in a manner which enables residents to mobilise freely. Bookshelves are evident with ex-library books for residents to access anytime in the small lounges.</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>	<p>FA</p>	<p>All laundry is undertaken on site by care staff who are employed to undertake both laundry and care duties seven days a week. Residents' personal items are laundered onsite or by family members if requested. Residents interviewed reported that laundry is well managed and their clothes are returned in a timely manner. The laundry is set up appropriately to meet the needs of the residents. A high standard is met by staff. The laundry is divided into dirty and clean areas for infection prevention and control purposes, is well ventilated, clean and tidy. There are combined policies and procedures for the laundry and cleaning which meet infection control standards. There are clear job descriptions for both roles. There are two large commercial washing machines and two commercial clothes dryers. Each resident has a basket for all clean personal clothes to be placed in before being returned to their individual rooms. There are two designated employed cleaners one of whom works four days a week and one cleaner two days a week. One staff member employed in a dual role position as cleaner/care staff member covers one day a week cleaning and provides relief as needed.</p> <p>Material data sheets are available and accessible as needed. The night care staff have a schedule to follow as do the day staff. The products for cleaning are wall mounted and dispensers work effectively when refilling the cleaning containers. The cleaning trolley is locked in the laundry when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for all emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 29 June 2000 and remains operative. A trial evacuation takes place six monthly with a copy of the drill sent to the New Zealand Fire Service, the most recent drill being the 17 November 2020. The orientation programme for all newly employed staff includes fire safety and security training. Staff interviewed confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones, torches, batteries and a gas barbecue were sighted and meet the requirement for 35 residents. All water bottles have been replaced this year. Water meets the requirements of the Auckland City Council for emergencies. Emergency lighting is available and this is checked monthly. There is no generator on site but provision for hire is available if needed. All emergency supplies are checked regularly with one large bin also being available with all emergency resources needed in an emergency. The facility manger checks the water temperatures monthly and this is recorded. The thermometer is calibrated annually.</p> <p>Call bells alert staff to residents requiring assistance. A new call bell system has been installed since the previous audit. Call system audits are completed on a regular basis and residents and families reported</p>

		<p>that staff responded promptly to call bells.</p> <p>Staff ensure the facility is locked at a predetermined time each evening and nursing staff do hourly rounds at night-time. Outside security lighting is available. Sensor door alarms are in located near the exit doors. Close circuit television cameras (CCTV) is used with the screen visible in the facility manager's office. Signage was sighted that to inform visitors, staff and residents that the CCTV is operating.</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>The residents' individual rooms and communal areas have opening external windows. The inner courtyard rooms have windows that open into the courtyard. The rest have open windows to the outside/external gardens. Electric fan heaters are provided that are wall mounted up high but the control cords are accessible for residents. There are heat pumps located in the hallways, main lounge and dining areas which work effectively for the large open spaces. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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 scope of the service.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimises the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual were reviewed in March 2020.</p> <p>Registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the FM and tabled at the infection control committee meeting. This committee includes the General Manager, Facility Manager and IPC coordinator.</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. Due to Covid 19 pandemic (currently level 1, on the day of audit), all visitors are requested to log their visit by entering their details on a paper log or by scanning the Ministry of Health bar code. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. 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</p>	FA	<p>The IPC coordinator is new to this role and has been supported by the FM who has appropriate skills, knowledge and qualifications for the role. The FM has attended relevant study days, 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</p>

infection control programme and meet the needs of the organisation.		an infection. There were no infections disease outbreaks reported in the facility since the last audit.
<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 reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in March 2020 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are 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 in infection prevention and control at orientation and ongoing education sessions. Education is provided 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 increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. Hand washing and donning doffing of personal protective equipment trainings have been completed as a part of recent pandemic preparedness.</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 increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, eye, respiratory tract, wound and other. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and</p>

<p>specified in the infection control programme.</p>		<p>required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the IPC committee. Data is benchmarked internally and compared against the previous year's data. This comparison has provided assurance that infection rates is lower than last years.</p> <p>Covid 19 pandemic preparedness document was sighted, and staff interviewed were aware of this plan.</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>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 provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures</p> <p>On the day of the audit no residents were using restraints and no residents were using enablers. No restraints have been used for more than five years. When enablers are used they are the least restrictive and used voluntarily by the resident at their request. The registered nurse is the restraint coordinator and has a job description for this role and the responsibilities are outlined.</p> <p>The service has a robust process when needed, which ensures the on-going safety and well -being of the resident.</p> <p>Restraint is used as a last resort when all alternatives have been explored. The annual restraint review was recently performed January 2021.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	CI	<p>All complaints both verbal and written are documented on the complaints register. Information is also gained on the 'share your feedback' forms reviewed which states on the form that 'the service welcomes your feedback, comments, nominations of employee heroes, any concerns or compliments'. The facility manager records any feedback as part of the complaints process and for quality improvement purposes. The register records complaints as minor and/or serious. The complaints are reviewed in a timely manner and responded to and all complaints can be followed through with all action undertaken and outcomes being clearly documented and dated. Complaint outcomes are discussed at the quality/staff meetings where applicable. Feedback is also provided to individual</p>	<p>Having fully attained this criterion the service can in addition clearly demonstrate that a full analysis of complaints and critique process occurs. Significant analysis and evaluation of outcomes and how the residents or staff have benefited from the individual complaint is reported in the monthly and annual summaries documented. A comparative study of the previous year's complaints is clearly documented. An example of evaluating the complaints process over this last year evidenced a positive outcome from a year when the nation went through a series of alert level lockdowns and visitors were unable to see residents throughout this time. This contributed to the mental health of some residents being compromised and staff coped more than adequately to provide support for affected residents over and above expectations. At times tensions did occur. However, staff provided a calm, family atmosphere and managed therefore to keep the level of complaints through these times to a minimum from both residents/families.</p>

		residents/family who have complained	
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	CI	<p>The facility manager and the regional manager interviewed clearly understood the organisation's quality and risk management system. Staff are involved in the internal auditing system at the required timeframes as allocated on the audit schedule developed and implemented. The registered nurse is responsible for recording the required clinical indicator information monthly. This information is later formally collated by the facility manager, analysed, graphed and the report provided to the general manager on a monthly basis. In addition, all relevant information is reported in a narrative form by the facility manager to explain outcomes and progress attained. Any recommendations or outcomes requiring further improvement or action are also included in the information provided to the general manager.</p>	<p>Having fully attained this criterion the service can in addition clearly demonstrate an ongoing review process and corrective actions are documented from the information gathered. In addition to the required clinical and non-clinical reporting obligations, a sample of narrative reports were reviewed which were comprehensive and provided clearly defined outcomes of quality improvements which have in one way or another totally benefitted the residents significantly. The site objectives set when the strategic plan was developed for Catherine Lodge were all effectively met. With a collaborative team approach and involvement of staff this enabled the goals to be achieved. The regional and general managers present at the audit, commented and endorsed the finding that the reports reviewed were the most comprehensively detailed reports provided by a facility manager across the organisation's three facilities. The comprehensive content of each internal audit report clearly described and demonstrated how changes occurring, whether clinical or non-clinical, was beneficial for the individual residents in relation to safety and care delivery.</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed</p>	CI	<p>Corrective action plans are widely used for all areas of service delivery as and when the service does not meet the desired standards or requirements. The audit summary is documented. Action plans are well documented on the action sheet developed and implemented. The records reviewed outlined, for example, the dates the audits were completed and the date discussed at the staff meeting. The name of the person completing the audit is also documented. The outcome score and the outcome of the last audit, recommendations, action to be taken and by whom, why improved or worsened on the last year's audit, completion date and signature is</p>	<p>Having fully attained the criterion, the service can in addition clearly demonstrate a review process including analysis and reporting of any findings, evidence of any action taken based on those findings and improvements to service provision and residents' safety or satisfaction as a result of the review process. All concerns and issues raised at the residents' meetings, audit results/outcomes, staff meetings and families input on an individual basis are entered onto a corrective action sheet or action sheet for audits. The date the audit is completed is documented, along with the outcome of the last audit, recommendations, action to be taken and by whom, why improved or worsened on last year's results is noted. Once the recommended action is fully implemented it is then signed off by the facility manager. All recommended actions are communicated to staff through the staff meetings and in the minutes of the meetings. Any outcomes or</p>

and implemented.		clearly documented to verify the action was completed with the desired outcome or standard being effectively met.	improvements are reported back to residents and families as appropriate so that they are kept well informed and reassured that any issues that have raised at the resident's meetings are fully addressed. The staff and residents interviewed confirmed they understood the process and when and how to report any concerns or issues they may have. Residents stated that they feel they can bring any issues or concerns to the forum of the resident meeting, however trivial they may seem and this benefits not just individual residents but all residents at Catherine Lodge.
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	CI	<p>The care staff and all staff are responsible for documenting any adverse, unplanned or untoward events including any short falls in order to identify opportunities to improve service delivery and to identify and manage risk appropriately and safely. Staff interviewed understand about reporting all incidents witnessed or unwitnessed or any near misses. In addition to this, any serious incidents are reported immediately to the facility manager and appropriate action or reporting would be completed to the appropriate agency as per the policy reviewed and interview with management staff who aware of their responsibilities and obligations to meet legislative requirements and health and safety requirements. The designated form is completed with all details including whether the family have been notified or the GP notified, or any urgent care required.</p> <p>The facility manager maintains the incident register which records all incidents, such as the date, location, any injuries sustained, whether a resident, staff member or visitor incident, time of the day and the hazard control identified is clearly documented. The number of incidents by type (eg, falls, skin tears, staff, medication, abuse, other fractures), are recorded and a key is used</p>	Having fully attained the criterion the service can in addition can clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken and based on those findings and improvements to service provision and residents' safety as a result of the review. The service has a comprehensive system in place for their reporting of adverse events concerning any residents, staff and other incidents/adverse events. The event reporting as described above is comprehensive and assists the facility manager to make appropriate choices around follow-up care and leading to a management and implementation plan with aims and objectives set for the coming year for quality improvement purposes.

		<p>to record appropriately the type of incident. At the end of the year the annual graph and analysis is printed out by the facility manager along with the incident summary for each type of incident for the year. In addition to this, an annual accident/incident analysis graph is printed with numbers of all types of incidents being graphed and colour coded. The summary reflects the total number of incidents reported for the year and is reflective and compared with the previous year's details. Reasoning for each type of incident is documented with the outcome summary. The plan for the next year is highlighted such as for the aim for 2020 is to reduce falls, skin tears and abuse incidents.</p>	
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End of the report.