# St Patricks Limited - St Patricks Home and Hospital

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** St Patricks Limited

**Premises audited:** St Patricks Home and Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 26 January 2021 End date: 27 January 2021

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 50

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

St Patricks Home and Hospital provides rest home and hospital (geriatric) levels of care for up to 60 residents. On the day of the audit there were 50 residents.

This certification audit was conducted against the health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The facility manager is a registered nurse (RN). She is appropriately qualified and experienced and is supported by a clinical manager and a team of experienced staff. Feedback from residents and families was very positive about the care and services provided.

This certification audit identified that one improvement is required in relation to health and safety. A rating of continuous improvement has been awarded around good practice.

## Consumer rights

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| --- | --- | --- |
| 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

Information about the services provided is readily available to residents and families/whānau. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent.

Cultural values and beliefs are understood and respected. Care planning accommodates individual choices of residents and/or their family/whānau. Informed consent processes are adhered to. Residents are encouraged to maintain links with their community.

Complaints processes are implemented, and complaints and concerns are managed appropriately. Very few complaints are received.

## Organisational management

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

Services are planned and coordinated and are appropriate to the needs of the residents. Quality and risk management processes are established. Business goals are documented for the service. The risk management programme includes a risk management plan, incident and accident reporting, and health and safety processes. Quality systems include regular monitoring of quality and risk data and an internal auditing programme.

Human resources are managed in accordance with good employment practice. An orientation programme and a regular staff education and training programme are in place. The facility manager/RN is on-site five days a week and shares on-call with the clinical manager when not on site. There are adequate numbers of staff on duty to ensure residents are safe. The residents’ files are appropriate to the service type.

## Continuum of service delivery

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| 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. |

Care plans are developed, maintained and reviewed by the registered nurses. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner.

A range of individual and group activities is available and coordinated by the activity’s coordinator. The activity’s coordinator and staff implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families reported satisfaction with the activities programme.

All meals are prepared on site. There are two culturally focused rotating seasonal menus in place, which are reviewed by a dietitian. Residents' food preferences are accommodated, and the residents and relatives reported satisfaction with the food service. There are nutritious snacks available at all times.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent healthcare assistants responsible for the administration of medicines complete education and medication competencies. The electronic medication charts are reviewed three-monthly by the general practitioner.

## Safe and appropriate environment

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| --- | --- | --- |
| 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. |

The building holds a current building warrant of fitness. All internal and external areas are safe and well maintained. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Chemicals are stored securely throughout the facility. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated (where applicable). Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. At least one first aid trained staff member is on duty at all times.

## Restraint minimisation and safe practice

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| 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. |

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. One resident was using a restraint and two residents were using an enabler at the time of the audit. The facility also has environmental restraint in place with appropriate measures undertaken to ensure it is safe and administered appropriately.

## Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 48 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 1 | 99 | 0 | 1 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 | The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. The facility manager/registered nurse (RN), clinical manager/RN and eleven staff interviewed (two RNs, three healthcare assistants (HCAs), one cook, one kitchen assistant, one diversional therapist, one activities coordinator, one maintenance, one cleaner) could describe how the Code is incorporated into their job role and responsibilities. Staff receive training on the Code during their induction to the service. This training continues via the staff education and training programme. |
| 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 give informed consent. | FA | There is an informed consent policy. Four hospital and four rest home residents’ files included signed general consent forms. These are available in English and Chinese (link CI 1.1.8). Residents are informed of and had signed to environmental consent to the gate at the front of the property being locked (accessed by keypad). For those residents without capacity, the enduring power of attorney (EPOA)/welfare guardian had signed the consent form to acknowledge the same. Care staff were knowledgeable around informed consent. Residents and relatives interviewed could describe what informed consent was and knew they had the right to choose. There is an advance directive policy.  There was evidence in files reviewed of family/EPOA discussion with the GP for a medically indicated not for resuscitation status. In the files reviewed, there were appropriately signed resuscitation plans and advance directives in place. Discussions with relatives demonstrated they are involved in the decision-making process, and in the planning of resident’s care. Admission agreements had been signed and sighted for all the files seen. Copies of EPOAs were on resident files where available. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Health and Disability advocacy details are included in the information provided to new residents and their family/whānau during their entry to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service. A resident advocate has been appointed who was a family member of a previous resident. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service encourages residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations.  Community links are established with local community groups. Residents who are able are supported to come and go from the facility as they please. One resident interviewed (rest home level) stated that she occasionally goes to visit her son for a few days on the North Shore, Auckland. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and families during the resident’s entry to the service. Complaints forms are located at the entrance to the facility. In addition to English, they have been translated to the Chinese language. The complaints process is linked to advocacy services.  A record of complaints received is maintained by the facility manager. Three complaints were lodged in 2020 (two verbal and one written) and no complaints have been lodged in 2021 (year-to-date). All three complaints were reviewed. Complaints are being managed in accordance with HDC guidelines. All three complaints lodged were successfully dealt with and resolved. Staff are kept informed, as evidenced in the staff meeting minutes.  Discussions with residents and families/whānau confirmed that they are provided with information on the complaints process and remarked that any concerns or issues they had, were addressed promptly. The resident survey results (December 2020) identified that residents and family were in need of greater information around the complaints process. This has been addressed in the December resident meeting. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code and the HDC advocacy service are included in the resident information that is provided to new residents and their families. The facility manager or clinical leader discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the residents’ meetings. Resident meetings are typically held monthly but have been less frequent due to Covid-19.  Interviews with four residents (two hospital and two rest home) and four family (hospital level) confirmed that the residents’ rights were being upheld by the service. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The residents’ personal belongings are used to decorate their rooms. The HCAs interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when care is being given and do not hold personal discussions in public areas. Three rooms are utilised as double rooms with privacy curtains installed.  HCAs reported that they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit confirmed that the residents’ privacy is respected. Shared toilets include appropriate door locking mechanisms.  Guidelines on abuse and neglect are documented in policy. Staff receive regular education and training on abuse and neglect, which begins during their induction to the service. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | A Māori health policy is documented for the service. One director is also a kaumātua of the Ngapuhi iwi who joined a staff meeting in March 2020 for the opening prayer (to protect the staff and residents from Covid-19). Rooms are blessed following the death of a resident. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents.  A Māori health plan is in place for residents who identify as Māori. Cultural considerations and interventions are identified around the domains of resident care, communication, restraint, challenging behaviours, food, and spirituality. There were no Māori residents living at the facility at the time of the audit.  Education on cultural awareness begins during the new employee’s induction to the service and continues as a regular/annual training topic. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies the residents’ personal needs and desires from the time of admission. Approximately 60% of the residents identify as Chinese. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. There is a minimum of one Chinese speaking staff on duty 24/7. A selection of documents are translated to Chinese (link CI 1.1.8).  Beliefs and values are incorporated into the residents’ care plans, evidenced in all eight care plans reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident’s plan of care, which included the identification of individual values and beliefs. The care staff reported that they are able to communicate with the resident using non-verbal communication if necessary. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the HCAs’ role and responsibilities. Professional boundaries are reconfirmed through education and training, staff meetings, and performance management if there is infringement with the person concerned. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | CI | The facility manager/RN is on site seven days a week (including visits over the weekends) and is supported by a full-time clinical manager/RN and a team of RNs. Both managers hold previous experience in physical rehabilitation and care of the elderly. Residents are reviewed by a general practitioner (GP) every three months at a minimum.  Residents and family/whānau interviewed reported that they are satisfied or very satisfied with the services received. This was also confirmed in the December 2020 resident/family satisfaction survey (sample of 24 respondents).  The service receives support from the district health board (DHB). A physiotherapist is on site once every two weeks to complete physiotherapy assessments and a physiotherapy assistant is employed full time to carry out the physiotherapy plans. A focus on physical rehabilitation and exercise programmes for the residents has resulted in two (hospital level) residents being discharged back to the community in 2020.  A van is available for regular outings. A podiatrist visits the facility every six weeks. The environment allows for close relationships between the staff and residents. One continuous improvement has been awarded around translating documents to the Chinese language. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The care staff interviewed understood about open disclosure and providing appropriate information when required.  Families interviewed confirmed they are kept informed of the resident’s status, including any events adversely affecting the resident. Fifteen accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.  An interpreter service is available and accessible if required through the district health board. Staff and family are used in the first instance. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | St Patricks Rest Home and Hospital provides rest home and hospital levels of care for up to 60 residents. Eight rooms are designated for rest home level of care and the remaining fifty-two rooms are designated as dual-purpose (hospital/rest home). On the day of the audit there were 50 residents (15 rest home and 35 hospital). This included one resident (hospital) on the long-term service chronic health conditions (LTS-CHC) contract. The remaining residents were on the aged residential care services agreement contract (ARRC).  A philosophy, mission, vision and values are in place. An annual business plan (2020) was implemented, with evidence of goals being reviewed. The facility manager is currently working on the 2021 business plan.  The facility manager (who is also one of the directors) is a Chinese speaking RN who has been in her role for four years and has previous experience working in physical rehabilitation and working with the elderly. She maintains a minimum of eight hours of professional development per year relating to the management of an aged care facility. |
| Standard 1.2.2: Service Management  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. | FA | The clinical manager is responsible for clinical operations in the absence of the facility manager. The other directors of the business would assume administrative responsibilities in the absence of the facility manager. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | A quality and risk management system is established, implemented and currently being updated for 2021. Policies and procedures align with current good practice. Policies have been reviewed, modified (where appropriate) and implemented. Reviews take place a minimum of two yearly or when changes occur (if sooner). New policies are discussed with staff as a regular agenda item in staff meeting minutes.  Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. Data collected for a range of adverse event data (eg, skin tears, falls [witnessed and unwitnessed] and infections) is analysed. An internal audit programme is being implemented. Corrective actions developed for areas identified for improvements (eg, complaints management, manual handling, infection control) indicate that these corrective actions have been successfully resolved. Staff are informed of quality results via staff meetings and handovers.  The facility manager is the health and safety officer. She is supported by a health and safety representative/HCA. Staff health and safety training begins during their induction to the service and includes a self-learning/competency package. Health and safety is a regular topic covered in the staff meetings. Actual and potential risks are documented on a hazard register, which identifies risk ratings and documents actions to eliminate or minimise each risk. One area identified for improvement is around orientating new contractors to health and safety processes as per the facility’s health and safety policy and procedures.  Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling. This includes (but is not limited to) sensor mats, regular toileting and intentional rounding. Prior to Covid-19, a falls prevention programme was established. This is scheduled to recommence. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the service’s quality and risk management programme.  Fifteen accident/incident forms were reviewed (witnessed falls and unwitnessed falls). Each event involving a resident reflected a clinical assessment and follow-up by an RN. Neurologic observations are conducted for suspected head injuries and unwitnessed falls.  The facility manager and clinical manager are aware of statutory responsibilities in regard to essential notification. No Section 31 reports have been required since the previous audit (February 2020). |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Seven staff files were randomly selected for review (two HCAs, one team leader/HCA, two staff RNs, one diversional therapist, one cleaner). Files included evidence of the recruitment and induction process, including reference checking, signed employment contracts, job descriptions and completed orientation programmes. The orientation programme provides new staff with relevant information for safe work practice that is specific to the position. Staff interviewed stated that new staff were adequately orientated to the service.  An education and training programme is provided for staff with very high attendance rates (80-90%). Competencies are completed specific to worker type and include (but are not limited to) medication, fire evacuation, resident care and handwashing. A register of current practising certificates for health professionals is maintained. Four of seven RNs have completed their interRAI training. A first aid trained staff is always available 24/7, including on outings. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing policy aligns with contractual requirements. The facility manager reports she is on site seven days a week and shares on-call with the clinical manager when neither are available on site. The clinical manager works full time Monday – Friday.  Staffing is flexible to meet the acuity and needs of the residents. Each shift (AM, PM and nights) is staffed with a minimum of one RN. Additional RN staffing is used when needed (eg, for interRAI assessments).  All HCAs work full (eight hour) shifts. Seven HCAs are rostered on the AM shift, seven days a week; and four HCAs are rostered during the PM shift. Two HCAs cover the night shift. Agency staff is used as necessary. The facility manager stated that currently agency staff are occasionally needed to replace HCA staff.  Separate staff are responsible for cleaning and laundry duties. A separate cleaner is employed full time (five days a week) and laundry staff work 10 pm – 6 am, seven days a week.  Interviews with residents and families confirmed staffing overall was satisfactory. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Archived records are secure in a separate locked area.  Residents’ files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant HCA or RN, including designation. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission information pack outlines access, assessment and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents and their families. Resident agreements are available in both English and Chinese and contain all detail required under the Aged Residential Care Agreement ( ARCC). The eight admission agreements reviewed meet the requirements of the ARCC and were signed and dated. Exclusions from the service are included in the admission agreement.  Family members and residents interviewed stated that they have the choice of the admission agreement in their preferred language and have received sufficient information prior to and on entry to the service. Family members reported that the facility manager or clinical manager are available to answer any questions regarding the admission process. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. The registered nurses interviewed could accurately describe the appropriate information required for transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. All legal requirements had been met. There are no standing orders in use. There are no vaccines stored on site.  The facility uses an electronic and robotic pack system. Medications are supplied two weekly, checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent healthcare assistants administer medications. Staff have up to date medication competencies and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridge and room temperature are checked daily and are within acceptable limits. Eye drops are dated once opened.  Staff sign for the administration of medications electronically. Sixteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. ‘As required’ medications had indications for use charted, and the effectiveness, once administered, was documented electronically and in the progress notes. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals are cooked on site. The kitchen was observed to be clean and well organised and a current approved food control plan expiring 3 December 2021 was evidenced. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. These are all within the accepted ranges. Food temperatures are checked at all meals. These are all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents’ dietary needs have been communicated to the kitchen. Special diets, likes and dislikes are noted on a kitchen whiteboard. There is a six-weekly rotating seasonal western menu, a two weekly rotating Chinese menu, a twice weekly Pasifika menu and a monthly Māori food option which have all been approved by an external dietitian. All resident/families interviewed are happy with the meals. Residents are free to choose from whichever menu appeals to them and can change between them at will. Additional snacks are available at all times. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents’ files reviewed. Initial interRAI assessments and reviews were evident in printed format in all resident files. Resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments were reflected into care plans. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident centred. Interventions documented support needs and provide detail to guide care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the dietitian, physiotherapist, podiatrist, wound care specialist and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident’s condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative’s health status and this was evidenced in the resident files sampled on the day of audit. Care plans have been updated as residents’ needs changed. The general practitioner interviewed was complimentary of the service and care provided.  Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.  There were no current wounds on the day of audit, however wound assessment, wound management and evaluation forms were sighted for four stage 2 and one stage 4 pressure injuries that had healed in the three months preceding the audit. Wound monitoring had occurred as planned and there were also photos to show wound progress.  Monitoring forms are in use as applicable, such as weight, vital signs and wounds. All monitoring requirements including neurological observations had been documented as required. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There is one activity coordinator, overseen by a part-time diversional therapist employed by the company at another facility, covering five days per week, who plans and leads all activities. Activities are also planned and set up for the weekends and overseen by the care staff on duty. On the days of audit residents were observed participating in activities delivered in both English and Chinese languages.  There is a weekly programme in large print (English and Chinese versions) on noticeboards in all areas. Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, walks outside, crafts, games, quizzes, entertainers, singing, English language lessons and tai chi.  Those residents who prefer to stay in their room have one-on-one visits to check if there is anything they need and to have a chat.  There are weekly outings, and the service utilises a wheelchair accessible taxi as needed. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers’ Day, Anzac Day and Chinese New Year are celebrated. There are visiting community groups such as choirs and children’s groups and the facility partners with two local schools to facilitate child/resident interaction.  Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.  Residents interviewed were positive about the activity programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Three of the eight resident care plans reviewed had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status. Five of the eight care plans reviewed were admitted in the last two months and did not require a review at the time of audit. Activities plans are in place for each of the residents and these are also evaluated or scheduled to be evaluated six-monthly. There are three-monthly reviews by the GP for all residents which family are able to attend if they wish to do so. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The clinical manager interviewed gave examples of where a resident’s condition had changed, and the resident had been reassessed for a higher or different level of care. Discussion with the clinical manager and registered nurses identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer’s labels and stored in locked areas. Safety datasheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available, located in the treatment room. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a building warrant of fitness which expires September 2021. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.  Electrical equipment has been tested and tagged, the next checks being due September 2021. The hoist and scales are checked annually and are next due to be checked March 2021. Hot water temperatures have been monitored in resident areas and are within the acceptable range. Flooring is safe and appropriate for residential care. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas, decked areas and gardens are well maintained. All outdoor areas have attractive features and are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | Twenty-five rooms have an ensuite, thirteen of the twenty-five rooms have a shared ensuite situated between two rooms with shared access. All rooms have hand basins. There are also sufficient communal toilets and showers. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. Privacy is assured with the use of ensuite bathrooms. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Fixtures, fittings, floorings and wall coverings are in good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All residents’ rooms are single apart from three which can be occupied by two residents. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care for residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are large and small communal areas. These include sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The dining area is open, homely and inviting. It is appropriate for the needs of the residents. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is done on site. The laundry is situated in a service area beneath the care home and is kept locked when not in use. There are clearly defined clean and dirty areas with a separate entry/exit. There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners’ equipment was attended at all times or locked away in the cleaners’ cupboard. All chemicals on the cleaner’s trolley were labelled. Sluice rooms were kept locked when not in use. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months (at a minimum) with the last fire drill taking place on 8 December 2020. There is a New Zealand Fire Service approved evacuation scheme.  The orientation programme and annual education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.  A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water, and blankets. A gas cooker is available on the premises.  The call bell system is in place that is linked to staff pagers. Residents were observed in their rooms with their call bell alarms in close proximity.  There is always at least one staff available 24 hours a day, seven days a week with a current first aid/CPR certificate. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. Staff and residents interviewed, stated that this is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free. |
| Standard 3.1: Infection control management  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. | FA | The clinical manager also fulfils the role of infection control coordinator (ICC) and has done for the past two years. Responsibility for infection control is described in the job description which was evidenced on the day of audit. The ICC oversees infection control for the facility, reviews incidents, and is responsible for the collation of monthly infection events and reports. The infection control programme is reviewed externally by a consultant who produces benchmarking which is shared between her client base. The consultant is also available for direction and advice via email and telephone. An infection control committee comprised of clinical and non-clinical staff meets three monthly as part of the infection control strategy.  The facility has a Covid-19/Pandemic plan in place and appropriate amounts of PPE on hand.  Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no outbreaks in the previous year. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC has attended online MOH and DHB training in infection control. There is access to infection control expertise within the DHB, wound nurse specialist, public health, laboratory and the external consultant. The GP monitors the use of antibiotics. The ICC also liaises and meets regularly with the infection control committee. Overall effectiveness of the programme is monitored by the infection control committee with external consultant oversight.  There are adequate resources to implement the infection control program at St. Patrick's Home and Hospital. The ICC liaises with the infection control committee who meet three monthly and as required (monthly during Covid lockdown). Information is shared as part of staff meetings and also as part of the registered nurse meetings. The ICC has completed online MOH and DHB training in infection control. External resources and support are available through external specialists, microbiologist, GP, wound nurse and DHB when required. The GP monitors the use of antibiotics. Overall effectiveness of the program is monitored by the infection control committee with external consultant oversight.  An organisation wide COVID strategy and pandemic plan was available to staff on site with education and associated resources relating to hand hygiene, PPE and donning/doffing procedures |
| Standard 3.3: Policies and procedures  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. | FA | The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by an external consultant who is well known and respected in the industry. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The ICC is responsible for coordinating education and ensuring staff attend the training available. Training on infection control is included in the orientation programme. Staff have attended infection control in-services in the last 12 months. The ICC has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection control coordinator/CM oversees infection surveillance for the service. Surveillance is an integral part of the infection control programme and is described in the facility’s infection control manual. Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends are identified, and analysed, and preventative measures put in place. These, along with outcomes and actions are discussed at the combined staff/health and safety and infection control meetings. Meeting minutes are available to staff. Results from laboratory tests are available as required. There have been no outbreaks in 2020.  Systems in place are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraint minimisation. One (hospital level) resident was using a lap belt as a restraint and two (hospital level) residents were using an enabler (bedrails). The facility has environmental restraint in place. The entrance door is kept locked with the code to exit placed in a visible location. Written consent has been obtained for residents who are unable to freely exit the facility.  Staff receive training on restraint minimisation, which includes testing their competency. The HCAs interviewed were able to describe the difference between an enabler and a restraint. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | A restraint approval process is in place. Restraint minimisation policies and procedures describe approved restraints including environmental restraint. The clinical manager is the designated restraint coordinator. She is knowledgeable regarding this role. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The restraint coordinator is responsible for assessing a resident’s need for restraint. Restraint assessments are based on information in the resident’s care plan, discussions with the resident and family and observations by staff. A restraint assessment tool is being implemented.  The resident file where restraint was being used was reviewed. This resident’s file included a restraint assessment, which included the identification of any risks associated with the use of the restraint. Restraint use was linked to the resident’s care plan.  Three files were sighted for residents that are environmentally restrained. The files included identification of the risks of the environmental restraint within the assessment. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | A restraint register is in place. The register identifies any residents using a restraint or enabler, and the type of restraint used (including environmental restraint). The restraint assessment reviewed identified that restraint is being used only as a last resort.  The frequency of monitoring residents while on restraint (other than environmental restraint where this is not indicated), is documented. Monitoring forms are completed when the restraint is put on and when it is taken off. There have been no adverse events reported as a result of restraint use. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Restraint use is reviewed six-monthly by the restraint coordinator, meeting requirements of the standard. Restraint use is discussed in the relevant staff meetings. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint programme, including reviewing policies and procedures and staff education, is evaluated as evidenced in the document control for restraint policies and procedures, in the meeting minutes and in discussions with the facility manager and restraint coordinator. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.9  Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented. | PA Low | Health and safety policies have been updated since implementation of the Health and Safety at Work Act. A hazard register is regularly updated. Health and safety is a regular agenda item in staff meetings. New staff are orientated to health and safety but there is no documented evidence to suggest that contractors complete a health and safety induction as per the facility’s health and safety policies and procedures. | There was no documented evidence to indicate that contractors are inducted into health and safety processes. | Ensure new contractors are inducted into the facility’s health and safety processes, as per policies and procedures.  90 days |

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

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | The admission agreement and consent form has been translated to Chinese for those residents and families whose primary language is Chinese. | Approximately 60% of the residents are Chinese. The majority of these residents and their families either do not speak/read English or it is their second language. In 2019, work began to translate the admission agreement and consent form to Chinese. The DHB was kept informed and supported this initiative. Implementation began in 2020. Evaluation of this initiative has been monitored via the uptake of forms, which has been very high for those residents and families who speak Chinese as their first language (they are offered both the English version and the Chinese version). They now can take these forms home to read and then return to discuss with the facility manager (vs only getting the detail verbally via the facility manager). Families have been asked to respond to this initiative and have stated that the translated forms are much easier to understand. |

End of the report.