

CHT Healthcare Trust - St Johns

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	CHT Healthcare Trust
Premises audited:	St Johns Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Residential disability services - Physical
Dates of audit:	Start date: 14 September 2015 End date: 15 September 2015
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:	65

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

St John's Hospital is owned and operated by the CHT Healthcare Trust and cares for up to 70 residents requiring hospital level and residential disability (physical) care. On the day of the audit, there were 65 residents. The service is overseen by a unit manager, who is well qualified and experienced for the role and is supported by a clinical coordinator and the area manager. Residents and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents and staff files, observations and interviews with residents, staff and management.

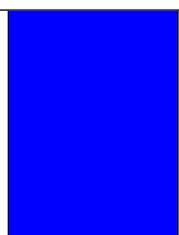
This audit has not identified any areas requiring improvement. The service has exceeded the required standard around implementation of the pillars of care, good practice and the service provided to residents at risk of weight loss.

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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Staff at St John’s strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner’s Code of Consumers’ Rights. Cultural needs of residents are met. Policies are implemented to support residents’ rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

<p>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.</p>	 <p>All standards applicable to this service fully attained with some standards exceeded.</p>
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The unit manager is a registered nurse and an area manager, a clinical coordinator, registered nurses and healthcare staff support her. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings have been held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. A comprehensive education and training programme has been implemented with a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

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

Primarily the clinical coordinator manages entry to the service with assistance from the registered nurses. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including InterRAI assessments. The registered nurses complete care plans and evaluations within the required timeframe. Care plans are based on the InterRAI findings and other assessments. They are clearly written and healthcare assistants report they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site by a contracted agency under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

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.

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. The facility is divided into eight suites, each with eight to ten residents. All bedrooms are single occupancy and have their own ensuite. There is sufficient space to allow the movement of residents around

the facility using mobility aids. There is an open plan lounge and dining area in each of the eight suites. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning contractors and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

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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St John's hospital has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were six residents with restraint and three residents with an enabler. Restraint management processes are adhered to.

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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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service

providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	2	48	0	0	0	0	0
Criteria	3	98	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (six healthcare assistants, two registered nurses (RN), one clinical coordinator, one area manager and one unit manager) confirm their familiarity with the Code. Interviews with nine residents including three under 65 years old confirm the services being provided are in line with the Code. The Code is discussed at resident and staff/quality meetings.</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>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Health care assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All nine of nine resident files sampled had a signed admission agreement signed on or before the day of admission and consents.</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>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff and residents informed they are aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register. Verbal and written complaints are documented. There have been 20 complaints in 2015 (year to date), six complaint forms were reviewed. All six complaints reviewed had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. Discussions with residents confirmed that any issues are addressed and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters of the code of rights on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the unit manager discusses the information pack with the resident and the family/whānau. Information pack includes a copy of the Code of Rights.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p>	FA	<p>The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were</p>

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.		met. There is a policy that describes spiritual care. Church services are conducted in the facility fortnightly. All residents interviewed indicated that resident's spiritual needs are being met when required.
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	The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. No residents identified as Māori on the day of the audit. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. Discussions with staff confirm that they are aware of the need to respond to cultural differences.
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 has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including residents cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural awareness.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies to guide practice that align with the health and disability services standards, for residents with aged care and residential disability needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects high levels of satisfaction with the services that are provided. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of

		<p>principles of aged care and stated that they feel supported by the management team.</p> <p>Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training.</p> <p>The service has exceeded the standard around good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incidents/accidents forms were reviewed. The forms included a section to record family notification. All ten forms indicated family were informed or if family did not wish to be informed. Residents interviewed confirmed that relatives are notified of any changes in their family member's health status.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	CI	<p>St John's Hospital is owned and operated by the CHT Healthcare Trust. The service provides residential disability and hospital level care for up to 70 residents. On the day of the audit, there were 65 residents. This includes six residents on younger persons with disability contracts and two on palliative care contracts. The unit manager is a registered nurse and maintains an annual practicing certificate. She has been with CHT Healthcare Trust for nine years and has been in the manager role since October 2005. The clinical coordinator has been in the role since November 2005. The unit manager reports to the area manager weekly on a variety of operational issues. CHT has an overall business/strategic plan and St John's Hospital and Rest Home has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement. The unit manager has completed in excess of eight hours of professional development in the past 12 months.</p> <p>The service has exceeded the standard around implementation of the Pillars of Care.</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</p>	FA	<p>In the absence of the unit manager, the area manager is in charge with support from the senior management team, the clinical coordinator and care staff.</p>

timely, appropriate, and safe services to consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is an organisational business/strategic plan that includes quality goals and risk management plans for St John's Hospital and Rest Home. Interviews with staff confirmed that quality data is discussed at monthly staff (Fonu) meetings to which all staff are invited. The unit manager advised that she is responsible for providing oversight of the quality programme. The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies are reviewed at national level, with input from facility staff every two years. New/updated policies are sent from head office, with a draft policy including InterRAI assessment requirements. Staff have access to manuals. Resident/relative meetings are held quarterly. Restraint and enabler use is reported within the quality meetings.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an accidents and incidents reporting policy. The manager and clinical coordinator investigate accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly quality meetings including actions to minimise recurrence. A registered nurse conducts clinical follow up of residents. Discussions with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</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</p>	FA	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Eight staff files were reviewed and evidence that reference checks were completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2014 has been completed and a plan for 2015 is being implemented. Sixty five percent of healthcare assistants have completed an aged care education</p>

the requirements of legislation.		programme including the dementia modules. The unit manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Seven of the nine registered nurses have completed InterRAI training. Three of these seven have been due to attend refresher courses and have attended these. Annual staff appraisals were evident in all staff files reviewed.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	CHT policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. At least one registered nurse on at any one time. A Lead R/N on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse.
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	The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The manager screens all potential residents prior to entry and records all admission enquires in a hard copy system. Residents interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager and clinical coordinator. The admission agreement form in use aligns with the requirements of the ARC contract.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential (yellow) aged care envelope that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur.

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 policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely in each resident's room. Medication administration practice complies with the medication management policy for the medication rounds sighted. Medication prescribed is signed as administered on the pharmacy generated signing chart. Registered nurses typically administer medicines although on occasion's medicines competent healthcare assistants may assist. All staff that administer medicines are competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medical practitioners write medication charts correctly and there was evidence of three monthly reviews by the GP. One resident self-administers their own medicines and the documentation was correctly recorded and a competency assessment completed.</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>	CI	<p>There is a fully functional kitchen and all food is cooked on site by contracted kitchen staff. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RNs on duty. The kitchen staff have completed food safety training. The kitchen manager and cooks follow a rotating seasonal menu, which has been reviewed in December 2014 by an external dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served. The service has exceeded the standard around meeting the specific dietary needs of residents.</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>The service records the reasons for declining service entry to residents should this occur and communicates this decision to residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Information on alternate placement options is given out.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools were completed and assessments were reviewed at least six monthly or when there was a change to a resident's health condition in files sampled. The InterRAI assessment tool is implemented. InterRAI assessments have been completed for all residents. Care plans are developed on the basis of these assessments.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The long-term care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings. The InterRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Registered nurses (RNs) (including the clinical coordinator) and HCAs, follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse [hospice nurse], or Huntington's chorea Society nurse or the mental health nurses). If external medical advice is required this will be actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, monitoring and wound management plans are in place for residents with seven wounds, which includes one resident with a stage two (recent) pressure area. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>Interviews with registered nurses, the clinical coordinator and HCAs demonstrated an understanding of the individualised needs of residents. Care plan interventions demonstrate interventions to meet 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</p>	<p>FA</p>	<p>Four activities coordinators are employed part-time to operate the activities programme for all residents. The programme operates seven days a week. Each resident has an individual activities assessment on admission, which is incorporated into the InterRAI assessment process. An individual activities plan is developed for each resident by the activities coordinators in consultation with the registered nurses. Each resident is free to choose whether they wish to participate in the group activities programme or their</p>

<p>are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. All long-term resident files sampled have a recent activities plan within the care plan and this is appraised at least six monthly when the care plan is evaluated or a further InterRAI assessment occurs. Residents interviewed commented positively on the activity programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The registered nurses evaluate all initial care plans within three weeks of admission. The long-term care plan is evaluated at least six monthly or earlier if there is a change in health status. There is at least a three monthly review by the GP. All changes in health status are documented and followed up. Reassessments have been completed using InterRAI LTCF for all residents who have had a significant change in health status since 1 July 2015. The RN completing the plan signs care plan reviews. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<p>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.</p>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed.</p>
<p>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.</p>	<p>FA</p>	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness. There is a maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. External areas are well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<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 are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. All bedrooms have their own ensuites. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</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>All residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</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>The communal areas include an open plan lounge and dining area in each of the eight to ten bed suites. These are large enough to cater for activities involving residents from other suites.</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>Contracted cleaning staff clean the facility. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All laundry is done off site. Residents interviewed were satisfied with the laundry service.</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>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back up power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</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>	<p>FA</p>	<p>General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.</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,</p>	<p>FA</p>	<p>St John's hospital has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The clinical coordinator (a registered nurse) is the designated infection control coordinator with support from the unit manager, the clinical coordinator and all staff as the quality management committee (infection control team). Minutes are available for staff. Spot audits have been conducted and include hand hygiene and infection control practices. Education is</p>

and visitors. This shall be appropriate to the size and scope of the service.		provided for all new staff on orientation. The infection control programme has been reviewed annually.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	A registered nurse at St John's hospital is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	There are CHT infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
Standard 3.5: Surveillance	FA	Infection surveillance is an integral part of the infection control programme and is described in CHT's infection control manual. Monthly infection data is collected for all infections based on signs and

<p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the unit manager. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were six residents with restraint and three residents with an enabler. Enabler use is voluntary. All necessary documentation has been completed in relation to the restraints. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers has been provided. Restraint has been discussed as part of quality meetings. A registered nurse is the designated restraint coordinator.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>A registered nurse is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in the three restraint and two enabler files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the files reviewed, assessments and consents were fully completed.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are obtained/ met.. There is an assessment form/process that is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular monitoring at the frequency determined by the risk level were present in the files reviewed. In resident files reviewed, appropriate documentation has been completed. The service has a restraint and enablers register which is up dated each month.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality meetings. Evaluation timeframes are determined by policy and risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly quality and health and safety meetings.</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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service has a variety of mechanisms used to provide a good practice environment. The area manager reported that learning's are shared across the CHT organisation. When interviewed, the unit manager reported using</p>	<p>The service has exceeded the standard by providing an environment and service that has best practice initiatives. Examples of this include the falls project, which has resulted in a significant reduction in the number of falls at the facility (link 1.2.1.1).</p> <p>In 2013, staff and management at St John's recognised there were significant numbers of residents admitted for end of life care to CHT St Johns, and were determined to provide the very highest standard of care to residents and their families at the end of residents' lives.</p> <p>Both DHB and hospice continued to refer their clients on for this purpose and the gradual aging and decline of longer-term residents supported a need to look at the LDL programme as a pivotal one for staff and residents and their families.</p> <p>Mercy Hospice and St Johns have had a long-standing relationship in which residents have had admission from either Mercy Hospice, or the community through referrals from the team at Mercy Hospice.</p> <p>Hospice Community registered nurses visit St John's each week (sometimes twice a week), to provide social and other support to their clients and by default they are very present for the support of the</p>

		<p>these learning's and being aware that St John's is a standalone hospital which provides different challenges than those of the other services in the organisation.</p>	<p>registered nurse team.</p> <p>The service has worked closely with the Auckland District Health Board (ADHB), who developed an initiative for the management of palliative care clients, communicated this to the sector through cluster meetings, and asked for participants in this initiative. St Johns volunteered to take up this programme, this was initially called the Liverpool care pathways (LCP), and the ADHB provided training and resources to manage and monitor this roll out. Each facility, including St John's had LCP training with the ADHB support team. Regular reviews are carried out with the DHB to monitor the effectiveness of this programme. CHT ensured this was adopted across the Trust, including St John's in 2013. A CHT Link Nurse was nominated for each site with St John's having two champions, who together cover seven days per week and both morning and night shifts.</p> <p>At the end of 2014, ADHB amended the programme from LCP to last days of life (LDL). CHT, including St John's has modified process and policy according to the recommended changes. All resources and documentation of the CHT quality system can be printed. The implementation and review of the LDL programme highlighted a number of factors that enabled staff within the unit to provide a more focussed and specific level of care to going through end of life. A decision was made to increase training across St John's for both registered staff and health care assistants in palliative care, LDL and death and dying/grief management. To ensure all areas & shifts were adequately covered, a full time night RN was sent to hospice & LDL training. Currently all RNs at St John's have had training in this area and have annual updates. Sixty percent of the HCAs have completed training to date. CHT has developed a series of brochures and handouts including relative/carer information around LDL, why residents on LDL do not always eat, what to expect when someone is dying and coping with bereavement.</p> <p>Registered nurses interviewed and review of meeting minutes highlighted benefits as follows:</p> <ul style="list-style-type: none"> • The GP & RN make a joint decision on when to set up the programme. • GP provides outline of medications for individual residents. • St John's has imprest stock of 'as required' medication on hand. • An RN can implement an LDL plan at any time or stage to meet residents' needs. • The GP outline includes breakthrough and varied doses, which enable RNs to access and tailor to meet residents' needs. • Training and support from hospice has been excellent. <p>The DHB and the hospice each provide formal annual feedback and this has been used to make changes to practice and to highlight areas for improvement. Areas around which plans to improve have been developed from this feedback includes further staff training, which has occurred in 2015 and a decision was made to have three rather than two Niki T Syringe Drivers to support pain management effectively.</p>
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<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>CHT has an organisation wide mission with pillars of care that are known and implemented at St John's Hospital and Rest Home.</p>	<p>CHT's logo is 'We take great care of older people'.</p> <p>Underpinning this is CHT's five pillars of care: compassion, comfort, companionship, care and quality of life.</p> <p>In late 2013 CHT including St John's, focused on one of these five pillars of care 'quality of life' and looked at ways to reduce falls for its residents as it recognised that falls prevention is not an isolated goal but part of a larger objective of promoting activity and improving quality of life.</p> <p>The aim was to reduce residents' falls, as it is a crucial aspect in reducing injury for residents.</p> <p>On investigating the reasons why residents fall at St John's and from analysing the trends, it was evident that a number of falls were as a result of residents trying to get out of bed unsupervised.</p> <p>Coupled with this was a concern around the use of bedrails as a falls management strategy in preventing residents from trying to get out of bed unaided. As with any form of restraint the service identified ongoing safety concerns and risks associated with restraint usage.</p> <p>As per CHT's restraint minimisation policy 'CHT will promote quality of life for residents by ensuring the use of restraint is kept to a minimum, and only used to ensure the safety of the resident, staff and other residents or visitors to the unit.'</p> <p>In attempting to reduce falls associated with residents getting out of bed unaided, a decision was made to</p>

			<p>purchase ultralow beds. Thirty of these beds are now in use at St John's.</p> <p>The objectives were:</p> <ol style="list-style-type: none"> 1. Reduce resident falls 2. Promote quality of life 3. Educate staff, the resident and the family on falls management strategies 4. Ensure CHT's falls management policy and other falls management documentation is current and reflects best practice 5. Reduce the use of bedrails for maintaining resident safety. <p>Falls are recorded in the electronic patient management system each month. This data is extracted monthly and analysed. The analysis includes identifying any specific trends for the resident (eg, time of fall, frequency of falls and number of falls over a rolling 12-month period). This information was graphed and is useful for highlighting to staff. Frequent fallers are also identified and from this falls management strategies are discussed at the monthly unit review meetings. This includes the use of low beds as a strategy. The unit manager, area manager, finance manager and the CEO, attends these meetings.</p> <p>Outcomes:</p> <p>There are 30 ultra-low beds now in use at St John's. Because of the use of these beds there has been:</p> <ul style="list-style-type: none"> • A reduction in falls for residents using ultra low beds and reduction in the potential for serious injury (there have been no serious injury falls for these residents). • All new residents have falls risk assessed using FRAT. • 'Falls' is now a standalone heading in the electronic care plan. • The falls management policy has been updated. • The falls checklist has been updated • There is a pictorial chart in place for each resident that identifies falls risk (sighted in residents' rooms). • The CHT manual handling programme has been updated. • A site 'champion' in manual handling has been appointed. • There are regular meetings with champions to identify falls management strategies for particular residents at St John's. • The CHT Focus on Care award was awarded to a St John's staff member for the management of
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			falls. <ul style="list-style-type: none"> Three residents no longer use bedrails as a result of using low, low beds.
<p>Criterion 1.3.13.2</p> <p>Consumers who have additional or modified nutritional requirements or special diets have these needs met.</p>	CI	<p>The facility has an appropriate food service in place for residents and all weights are monitored and documented monthly. There is dietitian input when weight loss is identified.</p>	<p>The service commenced using a Replenish Energy and Protein (REAP) programme in July 2012. REAP puts a focus on nutrition and 'nutrition alerts'. The documented programme has been developed by the external contractors dietitian and provides eligibility criteria and implementation guidelines for each level of REAP. The emphasis is on food first rather than commercial supplements for managing unintended weight loss. At St John's there are currently 22 residents on REAP. These residents are clearly documented on the whiteboard in the kitchen. When a resident is identified as having unintended weight loss, a weight loss report is completed. This includes checking the mouth and teeth, reviewing diet type, monitoring food intake, consulting with the cook, consulting the dietitian, referring to the GP, referring to family and reviewing medication. Two files were sampled for residents who have been on REAP. Both were assessed by a dietitian prior to commencement on REAP. Each of the two residents on REAP whose files were sampled have had weight gain. All staff are provided with annual training around REAP (last November 2014) with the kitchen staff receiving more detailed training. Seven of seven caregivers and three registered nurses interviewed are all familiar with REAP and report the benefits to residents. The cook interviewed reports that ways in which she implements REAP include fortifying food wherever possible for those on the programme. Examples include cream and brown sugar on cereals, extra margarine on vegetables, fortifying mashed potato, sauces and purees, cream on desserts in the evening, fortifying soup, providing fortified milk and fortified drinks, fortified custard for supper and sandwiches for supper. The service continues to evaluate and improve the REAP programme and initial results show a marked decrease in weight loss for those using the programme. The last review of the programme was in July 2015 with only minor changes made. The CHT external dietitian reviewed the food service in October to December 2014 and documented positive outcomes relating to residents on the REAP programme.</p>

End of the report.