CHT Healthcare Trust - Lansdowne Hospital and Rest Home

Introduction

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

The audit has been conducted by 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:	Lansdowne Hospital and Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 October 2015 End date: 13 October 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: 93

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

CHT Lansdowne is owned and operated by the CHT Healthcare Trust and cares for up to 95 residents requiring rest home or hospital level care. On the day of the audit, there were 93 residents. The service is overseen by a unit manager who is well qualified and experienced for the role, and is supported by an acting clinical coordinator and the area manager. Residents, relatives 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, relatives, staff and management.

This audit has identified areas for improvement around complaint management, staff orientation, InterRAI assessments and timeframe for completion, care plans and evaluations. The service has exceeded the required standard around implementation of the pillars of care 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.		Some standards applicable to this service partially attained and of low risk.

Staff at CHT Lansdowne 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. A complaints register is maintained.

Organisational management

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

The unit manager is a registered nurse and supported by an area manager, an acting clinical coordinator, registered nurses and care staff. 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 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Primarily the registered nurses or clinical coordinator manages entry to the service. There is comprehensive service information available. A registered nurse completes initial assessments. Care plans are written in a way that enables all staff to clearly follow their instructions. Residents and family 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. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives 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. All bedrooms are single occupancy, most with a shared toilet though there are a small number with their own ensuite. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of smaller lounge and dining areas throughout the facility. 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.

CHT Lansdowne 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 three hospital residents with restraint and one resident 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.

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	1	43	0	4	2	0	0
Criteria	2	92	0	5	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (six health care assistants, four registered nurses (RN), one acting clinical coordinator, one area manager and one manager) confirm their familiarity with the Code. Interviews with 11 residents (four rest home and seven hospital) and five relatives (two rest home and three hospital) confirmed the services being provided are in line with the Code. The Code is discussed at resident and staff/quality meetings.
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	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 completed a clinically indicated not for resuscitation order. Health care assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.

		Ten of 10 resident files sampled (three from the rest home and seven from the hospital) have a signed admission agreement and completed informed consent documentation.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	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, residents and relatives informed they are aware of advocacy and how to access an advocate.
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	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. On interview, all residents and relatives confirmed this and that visiting can occur at any time.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	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. There is a complaints register. Complaints for 2015 to date were reviewed. Verbal and written complaints are documented. There have been six complaints in 2015 to date. All complaints have noted investigation, time lines, corrective actions when required and resolutions. Results and outcomes of investigations were fed back to complainants, in three of the six complaints. Discussions with residents and relatives confirmed that any issues are addressed and they feel comfortable to bring up any concerns.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	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 EPOA to read with

		the resident and discuss. On entry to the service an RN, the clinical coordinator or the manager discusses the information pack with the resident and the family/whānau.
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 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 met. Staff were able to describe how they implement policies around abuse and neglect. There is a policy that describes spiritual care. Church services are conducted in the facility every week. All residents and relatives 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. Staff training includes cultural safety. The service is able to access Māori advisors as identified in the Māori health plan and policies. 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 and relatives 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 that the resident (if appropriate) and/or their family/whānau are asked to consult on.
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 were respectful. 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. 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 provided. Residents and relatives interviewed spoke very positively about the care and support provided. Staff had a sound understanding of principles of aged care and state that they feel supported by the management team. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents interviewed stated they were welcomed on entry and 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 viewed. The forms include a section to record family notification. All ten forms indicated that family were informed or if family did not wish to be informed. Relatives interviewed confirm they are notified of any changes in their family member's health status.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	CHT Lansdowne is owned and operated by the CHT Healthcare Trust. The service provides rest home and hospital level care for up to 95 residents. All beds are dual purpose beds. On the day of the audit there were 24 rest home and 69 hospital level residents. This includes one hospital level resident on short term respite care, one hospital resident on a younger person with disabilities contract and two residents funded by ACC (one rest home and one hospital). The unit manager is a registered nurse and maintains an annual practicing certificate. She has been in the role for one month and was previously the clinical manager at Lansdowne for six years. She is supported by an acting clinical coordinator. The organisation is actively

		recruiting for a permanent clinical coordinator. Management staff are supported by an area manager (also a registered nurse). The unit manager reports to the CHT area manager weekly on a variety of operational issues. The unit manager has completed in excess of eight hours of professional development in the past month (since she commenced in the manager's role). CHT has an overall business/strategic plan and CHT Lansdowne 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 required standard has been exceeded around implementation of the pillars of care.
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	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.
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.	FA	There is an organisational business/strategic plan that includes quality goals and risk management plans for CHT Lansdowne. There is evidence that the quality system continues to be implemented at the service. Interviews with staff confirmed that quality data is discussed at monthly quality 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. Staff have access to manuals. Resident/relative meetings are held. Restraint and enabler use is reported within the quality meetings. 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. There

		is a death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. All residents who have more than two falls have a post falls assessment completed by the physiotherapist. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.
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 accidents and incidents reporting policy. The unit 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. All 10 incident forms sighted confirmed that clinical follow up of residents is conducted by a registered nurse. Discussions with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is evidence of public health being involved around a resident who was found to have a notifiable disease (not acquired at the facility). One coronial inquiry has been completed with no recommendations for the service.
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.	PA Low	There are human resource management policies in place. 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. Nine staff files were reviewed and evidence that reference checks are 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. In eight of nine staff files sampled this checklist had been completed. The in-service education programme for 2014 has been completed and a plan for 2015 is being implemented. Healthcare assistants have completed an aged care education programme. The unit manager and registered nurses are able to attend external training including sessions provided by the local DHB. 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	Service policy for CHT includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. At least one registered nurse is on duty at any one time. Advised 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. Other residents or members of the public cannot view material containing sensitive resident information. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.
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 unit manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the unit manager and clinical coordinator. The admission agreement form in use aligns with the requirements of the contracts. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	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. Relatives interviewed confirmed they were kept well informed about all

		matters pertaining to residents, especially if there is a change in the resident's condition.
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	The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. 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 and senior health care assistants administer medicines. All staff that administers medication are competent and have received medication management training. The facility uses a robotic pack 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. Two residents self-administer medicines and both have a current competency assessment.
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.	CI	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 is 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 recently by a 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.
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	FA	The service records the reasons for declining service entry to residents should this occur and communicates this decision to residents/family/whānau. Anyone declined entry is referred back to the

organisation, where appropriate.		referring agency for appropriate placement and advice.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low	All relevant personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Relevant risk assessment tools were completed on admission and risk assessments were reviewed at least six monthly or when there was a change to a resident's health condition in files sampled. InterRAI assessments are occurring and all residents have been assessed to date. Though InterRAI initial assessments and assessment summaries were evident in printed format in all files, there were issues with the documentation. The care plans are developed on the basis of these assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Eight of nine (tenth file was for a respite resident) 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. Residents and their family/whānau are involved in the care planning and review process. Short-term care plans were in use for four of four hospital and one of two rest home files (link #1.3.8.2). Short-term care plans were utilised for changes in health status, were evaluated on a regular basis and signed-off as resolved or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialist care professionals. One respite resident file reviewed included an initial assessment, short-term care plan and regular progress notes. Staff interviewed reported they found the plans easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Registered nurses (RNs) (including the clinical coordinator) and healthcare assistants follow the care plan and report progress against the care plan each shift. If external nursing or allied health advice is required the RNs will initiate a referral (eg, to the district nurse). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is

		available as needed and this could be described. Wound assessment, monitoring and wound management plans are in place for 15 wounds including four pressure areas (three grade two and one grade one, all facility acquired). All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service. Interviews with registered nurses, the acting clinical coordinator and health care assistants demonstrated an understanding of the individualised needs of residents. Food and fluid charts are comprehensively completed as required. Care plan interventions and food and fluid charts demonstrate interventions to meet residents' needs (with exception #1.3.5.2).
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	Three activities coordinators are employed (two full time and one part time) to operate the activities programme for all residents. Each resident has an individual activities assessment on admission and from this information an individual activities plan is developed as part of the care plan by the registered nurses, with input from the activities staff. Residents are free to choose whether to participate in the group activities programme or their individual plan and 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 evaluated at least six monthly when the care plan is evaluated. Residents and families interviewed commented positively on the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate	The registered nurses evaluate all initial care plans within three weeks of admission. There is at least a three monthly review by the GP. An RN signs care plan reviews. Not all files evidenced that changes had been initiated to the care plan where progress was different from expected. 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.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services.

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. Staff provided examples of where a resident's condition had changed and the resident was reassessed.
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 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.
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 service displays a current building warrant of fitness. There is a full-time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment has been 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. The external area is 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.
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	There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Several bedrooms have their own ensuites. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.
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 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.
Standard 1.4.5: Communal Areas For Entertainment, Recreation,	FA	Communal areas include the main lounge, several smaller lounges and

And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		four separate dining areas. The communal areas are easily and safely accessible for 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	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 and relatives interviewed were satisfied with the standard of cleanliness in the facility. All laundry is done off site except kitchen laundry, personal items, facecloths and hand washed clothes. Residents and relatives interviewed advised that they were satisfied with the laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	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. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.
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	General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.

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	CHT Lansdowne 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. 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 provided for all new staff on orientation. The infection control programme has been reviewed annually.
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	A registered nurse at CHT Lansdowne 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.
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	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. Policies have been reviewed and updated.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	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 external 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 Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	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 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.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There were three hospital residents with restraint and one resident 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.
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 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.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. The files (two restraint and one enabler) sampled, demonstrated that these were undertaken by suitably qualified and skilled staff in partnership with the family/whānau. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the files (two restraint and one enabler) reviewed, assessments and consents were fully completed.

Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation manual identifies that restraint is put in place only where it is clinically indicated and justified and approval processes. An assessment form/process 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 two hourly monitoring 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 updated each month.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every six months. In the two restraint 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.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed six monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly quality meetings.

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Low	Healthcare assistants and registered nurses interviewed described appropriate processes they follow if a resident or family member wishes to make a complaint. Complaints are investigated by the manager or the clinical coordinator, depending on the nature of the complaint. There is documented evidence that all complaints have been investigated and corrective actions implemented. Three of six complaints have documented evidence that the outcome has been fed back to the complainant.	Three of the six complaints for 2015 do not have documented evidence that the outcome of the complaint was fed back to the complainant.	Ensure that the complainant is provided with the outcome for all complaints. 90 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme	PA Low	The service has a set of orientation questions to be completed by each new employee. These were completed in nine of nine staff files sampled. There is	One of nine staff files sampled does not have a completed orientation checklist.	Ensure all staff receive a comprehensive orientation and that this

that covers the essential components of the service provided.		a checklist that is signed by the staff member responsible for the orientation (the buddy) and the new employee to document that essential aspects of the onsite orientation have occurred. Eight of nine staff files sampled have this completed.		is documented. 90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Three files were reviewed of residents who had been admitted since 1 July 2015 (all directly from DHBs). Two of three residents (all hospital) had a completed InterRAI assessment within 21 days.	One of three hospital residents admitted since 1 July 2015 on a long-term contract, did not have an InterRAI assessment completed within 21 days of admission.	Ensure all residents admitted on a long-term contract have an InterRAI assessment completed within 21 days of admission. 90 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	All residents are assessed on admission. Initial and long-term care plans are then completed following assessment and reviewed in a timely manner. The provider had completed all their usual assessments following admission. Six of nine files reviewed had the InterRAI assessment summary completed fully.	Three of nine files reviewed (all hospital) did not have the InterRAI assessment summary comments completed to fully inform the care plans.	Ensure that the InterRAI assessment is fully completed including detailed comments. 90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	Eight out of nine long-term care plans described the support and interventions required to meet the resident's goals.	One hospital resident with unstable diabetes did not have the frequency of blood sugar monitoring stated in the care plan. The same resident's progress notes evidenced that they were receiving regular aperients but there was no bowel management stated in the care plan.	Ensure care plans fully document all interventions required. 60 days

Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	In three of five files reviewed for residents who have been at the service longer than six months, the long-term care plan was evaluated at least six monthly or earlier if there had been a change in health status (one file was a respite resident and four residents had not been at the service for six months). Evaluations do not always document progress toward goals.	In two (one hospital and one rest home) of five care plan evaluations reviewed, the evaluations did not evidence progress of goals for all care plans.	Ensure all evaluations document progress towards stated goals. 90 days
Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Moderate	Eight of ten files reviewed evidenced that changes in health status were documented and followed-up.	One rest home resident with recent pain does not have a short-term care plan commenced or their long-term plan updated to reflect this. One hospital resident with recent decline in health status does not have an updated care plan to reflect changed needs.	Ensure that all changes to residents' health status have relevant changes made to the care plan. 60 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	CI	CHT has an organisation wide mission with pillars of care that are known and implemented at CHT Lansdowne.	CHT’s logo is ‘We take great care of older people’. Underpinning this is CHT’s five pillars of care: compassion, comfort, companionship, care and quality of life. In mid-2013 CHT (including CHT Lansdowne) focused on one of these five pillars of care - ‘quality of life’ and looked at ways to reduce falls for its residents. It recognised that falls prevention is not an isolated goal, but part of a larger objective of promoting activity and improving quality of life. The aim was to reduce residents’ falls as it is a crucial aspect in reducing injury for residents. On investigating the reasons why residents fall at CHT Lansdowne 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. Coupled with this, was 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. 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. In attempting to reduce falls associated with residents getting out of bed unaided, a decision was made to purchase ultralow beds. A total of nine of these beds are now in use at CHT Lansdowne. The objectives were: 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. 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 e.g. 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 discussed at the monthly unit review meetings. This includes the use of low beds as a strategy. These meetings are attended by the unit manager, area manager, finance manager and the CEO. Outcomes: There are a total of 16 ultra-low beds now in use at CHT Lansdowne. As a result of the use of these beds there has been: • 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). • 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 resident's rooms). • The CHT manual handling programme has been updated. • A site 'champion' in manual handling has been appointed. • Regular meetings with champions to identify falls management strategies for particular residents at CHT Lansdowne. • There has been a reduction in the use of bedrails from seven in January 2015 to two at the time of the audit, and improved quality of life
Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.	CI	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.	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 Lansdowne there are currently 26 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. One file was sampled for a resident who has been on REAP and another who has commenced on REAP recently. Each of the two residents on REAP whose files were sampled, have had weight gain with one no longer requiring the programme. All staff were provided with training around REAP by

			the external contractors dietitian, with the kitchen staff receiving more detailed training. Health care assistants and registered nurses interviewed are all familiar with REAP and report the benefits to residents. The cook interviewed reports the ways in which she implements REAP includes 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.

End of the report.