

# CHT Healthcare Trust - CHT Bernadette

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## Introduction

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

The audit has been conducted by 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:

<b>Legal entity:</b>	CHT Healthcare Trust	
<b>Premises audited:</b>	CHT Bernadette	
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 20 January 2016	End date: 21 January 2016
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	70	

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

CHT Bernadette is owned and operated by the CHT Healthcare Trust and provides care for up to 113 residents requiring hospital and rest home level care. On the day of the audit, there were 70 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 identified areas requiring improvement around documenting indications for use for 'as required' medications.

## 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 Bernadette 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

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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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.		Some standards applicable to this service partially attained and of low risk.
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The clinical coordinator manages entry to the service with assistance from the registered nurses. Comprehensive service information is available. A registered nurse completes initial assessments, 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. Residents interviewed confirmed they were involved in the care planning and review process. The general practitioner reviews the residents at least three monthly or more frequently if needed.

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. Staff responsible for the administration of medication complete annual competencies and medication education. General practitioners review resident's medications at least three monthly.

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.
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The building has a current warrant of fitness and emergency evacuation plan. Reactive and planned maintenance is in place. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy and most have their own ensuite. There are adequate numbers of communal toilets and showers. There is sufficient space to allow the safe movement of residents around the facility using mobility aids. There are communal dining rooms and lounges in the rest home and hospital wings. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning contractors and laundry staff are providing appropriate services. Emergency systems and equipment are in place in the event of a fire or external disaster. There is a first aider on duty at all times.

## 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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CHT Bernadette 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 eight 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.

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.

## 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)
<b>Standards</b>	0	49	0	1	0	0	0
<b>Criteria</b>	0	100	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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, three registered nurses (RN), two activities staff, one clinical coordinator, one area manager and one unit manager) confirm their familiarity with the Code. Interviews with ten (six rest home and four hospital) residents and three families (all hospital) confirm the services being provided are in line with the Code. The Code is discussed at resident and quality/health and safety 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</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA sign 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 resident files sampled had a signed admission agreement signed on or before the day of admission.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>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 and family members 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. Twelve complaint forms were reviewed (all for complaints since the previous audit). All 12 complaints reviewed had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. One complaint was made to the Health and Disability Commissioner in July 2015. This continues to be investigated. One further complaint was made to the DHB and has been resolved. 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</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</p>

of their rights.		family/whānau. The information pack includes a copy of the Code of Rights.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>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.</p> <p>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.</p> <p>Staff have received training around recognising abuse and neglect since the previous audit and staff interviewed were conversant around this. There have been no reported incidents of abuse or neglect since the last audit.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. Two residents identified as Māori on the day of the audit.</p> <p>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.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>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, in which the resident (if appropriate) and/or their family/whānau are asked to consult on.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>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.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies to guide practice that aligns 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 provided. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of 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>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>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 reviewed (a sample from December 2015). 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 and family members 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>	<p>FA</p>	<p>CHT Bernadette is owned and operated by the CHT Healthcare Trust. The service provides hospital and rest home level care for up to 113 residents. On the day of the audit, there were 70 residents. This includes 32 rest home level residents and 38 hospital level residents including one person on younger persons with disability contract, two on long-term chronic conditions contracts and two on palliative care contracts. All rooms in the Matakana upstairs and downstairs and 'hospital' wings are dual purpose and 11 specific rooms in the rest home area are dual purpose (although there are currently no hospital level residents in the rest home wing). The unit manager is a registered nurse and maintains an annual practicing certificate. She has been with CHT Healthcare Trust since 2010 and has been in a manager role at another facility until undertaking this role in August 2015. The clinical coordinator has been in the role since November 2015, having previously</p>

		acted in the role. The unit manager reports to the area manager weekly on a variety of operational issues. CHT has an overall business/strategic plan and Bernadette 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>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	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>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 Bernadette. The quality system at Bernadette was fully established in October 2015 following the previous audit in September 2015. Interviews with staff confirmed that since this time quality data is discussed at monthly staff 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 now 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 area manager completed a comprehensive internal audit in November 2015 covering all aspects of the service. Following this a number of corrective action plans were developed, all of which have been actioned and implemented. The service has a recently improved 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. Resident focus groups have been held around areas identified as requiring improvement in the September 2015 survey.</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. Twelve incident forms sampled from December 2015 included appropriate follow up by a registered nurse and investigation of incidents to identify areas to minimise the risk of recurrence. Discussions with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Appropriate notifications have been made to HealthCERT and the DHB.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	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 for staff that have commenced employment since the previous audit and these evidence appropriate employment practices including 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 2015 has been completed and a plan for 2016 is being implemented. The unit manager and registered nurses are able to attend external training, including sessions provided by the local DHB.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>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 is on duty at any one time. Senior staff on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p>	FA	<p>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</p>

<p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>are not able to view sensitive resident information. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>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 clinical coordinator 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 aligns with the requirements of the ARC contract.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>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 DHB hospital transfer form and yellow aged care envelope system. Relatives are notified if transfers occur.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>The medication management policies and procedures comply with medication legislation and guidelines. The RN on duty checks medications against the medication chart. Registered nurses administer medications and have completed competencies including syringe driver competency. Senior HCAs have completed medication competencies. Medication administration practice complies with the medication management policy for the medication administration sighted. Medication prescribed is signed as administered on the pharmacy generated signing chart. There is one resident who self-administers their own medicines and the documentation was correctly recorded and a competency assessment completed. Standing orders are not in use.</p> <p>Eighteen medication charts were reviewed. All medication charts had been reviewed at least three monthly. Medication charts met the legislative requirements for the prescribing of regular medications. Not all prescriptions for 'as required' medications document the indication for use.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>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. The kitchen is able to meet the needs of residents who require special diets and the chef manager works closely with the RNs on duty. The kitchen staff have completed food safety and chemical safety training. The kitchen manager and cooks follow a rotating four weekly seasonal menu, which has been reviewed by the contracted company's dietitian. The cook (interviewed) was able to describe alternative meals offered for residents with dislikes and the Replenish Energy and Protein (REAP) programme for weight loss. 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 happy with the quality and variety of food served.</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>	FA	<p>Files sampled demonstrated that 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 the outcomes of assessments were reflected in the long-term care plans in resident files reviewed. The InterRAI assessment tool has been completed for all residents. The InterRAI assessments are completed six monthly or earlier if there are changes to the resident's health status.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service</p>	FA	<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. Residents and relatives confirmed they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Care staff interviewed reported the care plans are readily available and they found the plans easy to follow.</p>

delivery.		
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>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 as evidenced in resident files. If external medical/specialist advice is required, this is initiated by the GP.</p> <p>Staff have access to sufficient dressing supplies. Sufficient continence products are available and resident files include a continence assessment and plan in the care plan. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, monitoring, wound management plans and short-term care plans are in place for 11 skin tears, one surgical wound, two ankle ulcers and one hospital resident with a grade 2 sacral pressure injury (see hospital tracer). The RNs have access to specialist nursing wound care management advice through the district health board. Appropriate pressure injury interventions were documented in the care plans of residents identified as high risk of pressure injury</p> <p>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 are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>A team of one diversional therapist and two activity coordinators are employed to deliver the activities programme seven days a week. The activities provided meet the recreational preferences and abilities of the resident groups and include art and crafts, exercises, walks and board games. Activities reflect ordinary patterns of life and include planned visits to the community. Activities are held in the rest home and hospital lounges, with some activities integrated such as happy hour, entertainment and bowls. One-on-one time is spent with residents who choose not to or are unable to participate in group activities.</p> <p>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 in consultation with the resident/family. All long-term resident files sampled have a recent activities plan within the care plan and this is reviewed 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</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	FA	<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 is documented and followed up. Six monthly reassessments have been completed by RNs using InterRAI LTCF for all residents and for those who have had a significant change in health status. Short-term care plans are evaluated and resolved or added to the</p>

manner.		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.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other medical and non-medical services such as dietitian, social workers, psychiatry services and retinal screening. 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 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	FA	The building has a current building warrant of fitness that expires 22 April 2016. The facility is a two level building (ground floor and first floor) with lift and stair access. A full-time maintenance manager oversees three facilities and has a part-time maintenance team. There is a reactive (maintenance communication book) and planned maintenance plan in place for the internal and external building. All electrical equipment is tested and tagged two yearly. Clinical equipment is checked and calibrated annually. Hot water temperatures are monitored and managed within 43-45 degrees Celsius.  All rooms in the hospital areas (the hospital, Matakana upstairs and Matakana downstairs) are dual purpose

purpose.		<p>and suitable for either rest home or hospital level residents. In the rest home area, rooms AW 1,2,3,5,6,9,12,17 and 18 and GW 4 and 8 are dual purpose and able to accommodate either rest home or hospital level residents.</p> <p>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 communal toilets and shower/bathing areas for residents. All communal toilets and shower rooms have vacant/engaged slide signs. Not all bedrooms have ensuites. Bedrooms in the newer part of the building all have ensuites. Some of the older rooms have toilets and hand basins. 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 cares to be provided for the assessed level of care 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</p>	FA	<p>The communal areas include a large open plan lounge and smaller seating areas. Activities take place in a number of areas throughout the facility. There is a rest home and hospital resident dining room. Communal rooms are easily accessible.</p>

appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry and cleaning is done on-site by a contracted service. A laundry/cleaning supervisor oversees the service. The laundry is an external building with internal access to the facility. There are entry and exit doors and there are defined clean/dirty areas. Cleaning trolleys are well equipped and are stored safely when not in use. The staff have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness and laundry process is monitored through the internal audit programme.</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>	FA	<p>The fire evacuation plan was reviewed and approved by the fire service in November 2014, following building alterations. 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. Fire training and security situations are part of orientation of new staff and include competency assessments. There are adequate supplies in the event of a civil defence emergency including food, water and gas cooking. A generator is supplied through a contracted service when required. Short-term back up power for emergency lighting and the call bell system 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. The call bell system in the older part of the building is currently being upgraded to link with the main call bell system in the hospital wing.</p> <p>The building is secure afterhours and there are night time security rounds carried out by a contracted security service.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an</p>	FA	<p>General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open and allow plenty of natural sunlight.</p>

environment that is maintained at a safe and comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>CHT Bernadette has an 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 included hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>A registered nurse at Bernadette 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>
<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</p>	FA	<p>There are CHT infection control policies and procedures appropriate 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>

organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
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 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 commenced in December 2015, following training of registered nurses around reporting infection occurrences by the infection control coordinator. It is described in CHT's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection since December 2015. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. Outcomes and actions are discussed at the quality/health and safety meeting. 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 eight 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 that 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/health and safety meetings. A registered nurse is the designated restraint coordinator.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining	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.

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.		
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. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in the two 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 two restraint and two enabler files 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 put in place only where it is clinically indicated and justified and approval processes are obtained/met. 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 monitoring at a 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 updated each month.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	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.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the	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. The restraint coordinator completes reviews. Any adverse outcomes are reported at the monthly quality and health and safety meetings.

monitoring and quality review of their use of restraint.		
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	Sixteen of 18 medication charts had the indication for use of ‘as required’ medications. The supply of ‘as required’ medications is checked for expiry dates and replaced at least three monthly or earlier as required. The GP reviews the use of ‘as required’ medications at least three monthly.	Two of eighteen medication charts did not have a prescribed indication for use for ‘as required’ medications (including clonazepam, haloperidol, oxynorm and rivotril).	<p>Ensure all ‘as required’ medications have an indication for use on the medication chart.</p> <p>90 days</p>

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

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

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

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

No data to display
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End of the report.