

CHT Healthcare Trust - Onewa 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:	Onewa 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: 30 June 2016 End date: 1 July 2016
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	70

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
Yellow	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
Red	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 Onewa is owned and operated by the CHT Healthcare Trust and cares for up to 70 residents requiring hospital and rest home level care. On the day of the audit, there were 70 residents. A unit manager, who is a registered nurse and is well qualified and experienced for the role, oversees the service and is supported by the area manager.

Residents and the GP interviewed spoke positively about the service provided.

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

This audit has not identified any areas requiring improvement.

The service is achieving three continual improvement ratings relating to falls reduction, weight management and infection control.

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 Onewa 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.

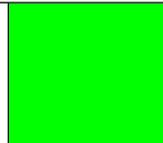
Organisational management

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 quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted and these generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents/family meetings have been held and residents and families are surveyed regularly. 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.



Standards applicable to this service fully attained.

A registered nurse is responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information gained through the initial support plans, specific assessments, discharge summaries, and the care plans to guide staff in the safe delivery of care to residents. The care plans are resident and goal orientated and reviewed every six months or earlier if required with input from the resident/family as appropriate. Allied health and a team approach are evident in the resident files reviewed. The general practitioner reviews residents one to three monthly.

The activities team implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

Medications are managed appropriately in line with accepted guidelines. The registered nurses administer medications, and have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Nutritious snacks are available 24 hours.

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. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All except one resident room is single occupancy and the majority have ensuite while some share ensuite. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are several 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. Cleaners and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Onewa 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 two 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. 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	0	50	0	0	0	0	0
Criteria	3	98	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (three healthcare assistants, two registered nurses (RN), two activities coordinators, one area manager and one unit manager) confirm their familiarity with the Code. Interviews with nine residents (four rest home and five hospital) and three families (three hospital) confirmed the services being provided are in line with the Code. The Code is discussed at resident and staff/quality meetings.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Nine resident files sampled (four rest home including one respite and five hospital) demonstrated that advanced directives are signed for separately. There was evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Healthcare 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>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>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>	<p>FA</p>	<p>Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of complaints process. A complaints form is freely available for residents and relatives. Information about complaints is provided on admission. Interviews 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 computerised complaints register. Verbal and written complaints are documented. There were two complaints in 2016 and all complaint documentation was reviewed. Both complaints had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants and discussed in meetings, as relevant. Discussions with residents confirmed that any issues are addressed and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There are posters of the Code 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 given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the clinical coordinator discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code of Rights.</p>
<p>Standard 1.1.3:</p>	<p>FA</p>	<p>The service has policies, which align with the requirements of the Privacy Act and Health Information</p>

<p>Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>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>A policy describes spiritual care. Church services are conducted three times a month and the chaplain visits most days. All residents interviewed indicated that residents' spiritual needs are being met when required.</p> <p>There is a policy on abuse and neglect and staff have received training. Staff interviewed were aware of the service zero tolerance to abuse.</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. One resident identified as Māori on the day of the audit. The resident InterRAI and care plan reflected Māori Tikanga.</p> <p>Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review, as demonstrated in resident files sampled. Discussions with staff confirmed 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.</p> <p>Information gathered during assessment including residents cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural awareness. The service currently has some Chinese residents, for which staff and family are able to provide interpreter services.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<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 in September 2015 reflected 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>CHT Onewa has implemented a number of initiatives that provide examples of good practice. They include (but are not limited to):</p> <ol style="list-style-type: none"> 1. Renovation of the rest home side of Onewa – painting and new carpets 2. Installation of an upgraded call bell system 3. Implemented an electronic medication documentation system on the 24th May 2016 4. The introduction of quality teams with all staff now belonging to a quality team (link CI 1.2.3.6) 5. A focus on HCA training resulting in 93.1% or 27 staff having completed ACE advance, 83.9% or 31 staff having completed ACE dementia and 89.7% or 29 staff having completed ACE core
<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 of 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 (six hospital and four rest home). 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. Relatives interviewed confirmed that they 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</p>	<p>FA</p>	<p>CHT Onewa is owned and operated by the CHT Healthcare Trust. The service provides rest home and hospital level care for up to 70 residents. On the day of the audit, there were 28 rest home level (including two respite residents) and 42 hospital level residents. There are 64 dual-purpose rooms. Onewa is part of the CHT northern regions and lead by an area manager who is a practicing registered nurse.</p>

<p>appropriate to the needs of consumers.</p>		<p>The unit manager is a registered nurse and maintains an annual practicing certificate. She has been in a management role at the facility for three years and was previously a clinical coordinator at another CHT facility. The unit manager reports to the area manager weekly on a variety of operational issues. CHT has an overall business/strategic plan and Onewa 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.</p> <p>The unit manager has completed in excess of eight hours of professional development in the past 12 months.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the unit manager, the clinical coordinator is in charge with support from the senior management team and the area manager.</p>
<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>	<p>FA</p>	<p>There is an organisational business/strategic plan that includes quality goals and risk management plans for Onewa. Interviews with staff confirmed that 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.</p> <p>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.</p> <p>Resident/relative meetings are held monthly and a quarterly newsletter is sent to all family and residents.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service has exceeded the required standard around the development of quality teams has been effective in reducing negative outcomes for residents.</p> <p>There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an accidents and incidents reporting policy. The unit manager along with the health and safety team investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly quality meetings as well as quality, and health and safety team meetings, including actions to minimise recurrence. A registered nurse conducts clinical follow-up of residents. Ten incident forms sampled demonstrated that appropriate clinical follow-up and investigation occurred following incidents.</p> <p>Discussions with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A section 31 notification was made regarding a stage 4 pressure injury and an outbreak in July 2015 was appropriately notified.</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. Seven staff files were reviewed (two registered nurses, an activities coordinator and four healthcare assistants) and evidence that reference checks were completed before employment was provided.</p> <p>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. Seven of the eight registered nurses have completed InterRAI training and one is in progress. Annual staff appraisals were evident in all staff files reviewed.</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 two registered nurses are on at any one time for morning and afternoon shifts and one at night. The registered nurse on each shift is aware that extra staff can be called on for increased resident requirements. The service is divided into teams and staff have allocated residents to ensure they get to know the resident well. 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</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</p>

<p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>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 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 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 manager and clinical coordinator.</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 admission to hospital are managed appropriately and relevant information is communicated to the DHB. The facility uses the transfer (yellow) aged care envelope. 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>FA</p>	<p>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 round sighted. The facility has just commenced using an electronic medication system. This is a new process and it is being closely monitored on a daily basis. Any problems are documented, discussed and attended to immediately. Prescribed medication is signed as administered electronically. Registered nurses administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medical practitioners (GPs) prescribe medications electronically. These were charted correctly and there was evidence of three monthly reviews by the GP. Two residents self-administer their own medicines, and the documentation was correctly recorded and a competency assessment was completed.</p> <p>Eighteen medication charts were reviewed. All electronic charts had a photo ID, allergy status was</p>

		recorded and 'as required' medications had prescribed indications for use.
<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 well-equipped kitchen and all food is cooked on site by contracted kitchen staff (one cook during the week and one at the weekends, two kitchen hands and one baker Monday to Thursday). There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and the profile 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 cooks follow a four weekly seasonal menu, which is reviewed by a dietitian. The service has exceeded the required standard around the management of weight loss. 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 happy with the quality and variety of food served. There was evidence that there are additional snacks available over 24 hours.</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 potential residents should this occur and communicates this decision to potential residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</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 indicated that all appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. Files sampled contained appropriate completed assessment tools and assessments that were reviewed at least six monthly or, when there was a change to a resident's health condition. The InterRAI assessment tool is implemented. InterRAI assessments have been completed for all residents. Care plans sampled were developed based on these assessments. Additional assessments for management of behaviour and wound care were appropriately completed according to need.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The long-term care plans reviewed described the support required to meet the resident's needs and goals, and identified allied health involvement. The InterRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. The resident or relatives sign long-term care plans. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow. There was documented input from a range of specialist care professionals including the podiatrist, physiotherapist, specialist wound care nurse and the mental health team.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Registered nurses (RNs) and healthcare assistants (HCAs) follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the wound care nurse specialist or the mental health team). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available through the DHB.</p> <p>Wound assessment, monitoring, and wound management plans are in place for six residents with wounds (one chronic leg ulcer and five skin tears) and three residents with pressure injuries. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the DHB.</p> <p>Interviews with registered nurses and HCAs demonstrated an understanding of the individualised needs of residents. Care plan interventions demonstrate interventions to meet residents' needs. There was evidence of pressure injury prevention interventions such as two hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management. The service has commenced the REAP plan around weight management for residents with initial results showing improved outcomes for residents with weight loss.</p> <p>Monitoring forms such as weight, observations and wounds are in use as applicable. Behaviour charts were in use for any residents that exhibit challenging behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	<p>FA</p>	<p>One diversional therapist (38 hours Monday through Friday) and one activity assistant (four hours Monday through Saturday) operate the activities programme. In addition, an activities assistant works two hours on a Sunday. Each resident has an individual activities assessment on admission, which is incorporated into the InterRAI assessment process. An individual activities plan is developed for each resident by the activities coordinators in consultation with the registered nurses. Residents are free to choose whether</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>they wish to participate or not. There is a wide variety of activities available. Special events such as birthdays, Chinese New Year, Easter are celebrated. Those who prefer to stay in their rooms have one-on-one visits. Participation is monitored. There is a fortnightly van outing and a monthly community afternoon-tea group with entertainment run by a church group. Church services are available for all denominations. 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 or a further InterRAI assessment occurs. Residents interviewed commented positively on the activity programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The nine files sampled demonstrated that the InterRAI assessment and long-term care plan were evaluated at least six monthly or earlier if there was a change in health status. There was at least a three monthly review by the GP. All changes in health status were documented and followed up. The RN completing the plan signs the care plan reviews and then gives it to the resident or relative to read and sign. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. Evidence of referrals was sighted on three files sampled.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous</p>	<p>FA</p>	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available.</p>

substances, generated during service delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness. There is a maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed to within 43-45 degrees Celsius. All communal areas, hallways and resident rooms are carpeted. All ensuites, showers and utility areas have non-slip vinyl flooring. The facility has sufficient space for residents to mobilise using mobility aids and residents were observed moving around freely. 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 32 rooms with toilets and hand basins, 29 rooms with shared toilets and hand basins and 8 rooms with hand basins only. There are adequate communal showers and toilets. Fixtures, fittings and flooring are appropriate and toilets/showers are constructed for ease of cleaning. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with</p>	FA	<p>The communal areas include two large lounges and dining areas, and several smaller lounges. These are large enough to cater for activities (as observed taking place). Seating and space can be arranged to allow both individual and group activities to occur. There are sufficient communal areas for residents who prefer quieter activities or visitors to sit.</p>

<p>safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The cleaners have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility. Cleaning trolleys are stored in a locked cupboard when not in use. Safety data sheets are available.</p> <p>All laundry is completed off site.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment, including fire equipment. Fire training and security situations are part of orientation of new staff. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back up power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms and these were observed to be within close proximity.</p> <p>There is security lighting at night and access to the building is by bell. There are random night security guard patrols.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and</p>	<p>FA</p>	<p>There is central heating throughout the facility. Some residents who feel the cold also have oil heaters in their rooms. All rooms have external windows that open, allowing plenty of natural sunlight.</p>

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>Onewa has an established infection control programme. The IC team who meet monthly leads the programme. Monthly reports from the IC team are integrated into the quality team meetings. 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 all staff and the infection control team. 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.</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>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team 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 organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service</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>

provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>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 attends the Tauranga infection Control Forum, and provided with education and updates through this forum. 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.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and 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. An outbreak of norovirus in June 2015 was appropriately managed.</p> <p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinators collate information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports are completed for all infections. Infections are analysed for trends and quality improvements. Graphs and relevant information is communicated to staff, and documented in management and staff/quality meetings.</p> <p>Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP who advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>The service has exceeded the required standard by using surveillance data to improve resident outcomes.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were eight residents with restraint and two residents with an enabler. Five residents have bedrails as a restraint, seven have lap belts and one has table top restraint during meals (some residents have more than one restraint approved). The two enablers were bed rails, both files sampled documented that enabler use is voluntary.</p> <p>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</p>

		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 and monthly, as part of the restraint group. A registered nurse is the designated restraint coordinator and the lead of the restraint team.
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. The assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident or representative and medical practitioner. The restraint team monitors and checks all restraints at least monthly.
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 four restraint and two enabler files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the files reviewed, assessments and consents were fully completed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are obtained/met. 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 the frequency determined by the risk level were present in the files reviewed, and appropriate documentation has been completed. The service has a restraint and enablers register, which is updated each month.
Standard 2.2.4: Evaluation	FA	The service has documented evaluation of restraint every three months. In the files reviewed, evaluations

<p>Services evaluate all episodes of restraint.</p>		<p>had been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every month at quality meetings, by the facility restraint coordinator. Evaluation timeframes are determined by policy and risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. The restraint coordinator and the restraint team complete reviews. Any adverse outcomes are reported at the monthly quality, and health and safety meetings.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	All clinical and non-clinical staff at CHT Onewa are allocated to specific quality teams over a 12 month period. These teams are compiled of registered nurses, healthcare assistants, physiotherapists, the chef, and activities coordinators as needed. Each team collects statistics each month and prepares a summary report that is shared with all staff at the registered nurse meeting and monthly staff meeting. Training sessions are based on findings identified in these trend analysis reports. The teams include health and safety, infection control, restraint, the skin care and pressure injury team, the continence team, the REAP (weight management team).	The development of quality teams has been effective in improving outcomes for residents. An example includes: Falls were noted to be high for the service during 2014 and Onewa reported the highest falls in the CHT group. The health and safety group took a proactive approach and undertook a root cause analysis of falls. Monthly reports to the quality team documented where and when falls were occurring, common themes for falls and identification of frequent fallers. Falls prevention strategies were implemented that reflected their root cause analysis including (but not limited to) shower mats for showers as residents were reported as slipping in the shower, an exercise programme for residents, and ensuring residents are part of the Vitamin D programme. More sensor mats were purchased. All call bells have clips to attach cords to be near residents. Additional training was provided around falls prevention with staff. The health and safety group also undertake ‘walk rounds’ to ensure falls prevention strategies are always implemented.

			<p>On evaluation of the effectiveness of these measures (which they undertake monthly), they noted a drop in falls incidents. During 2014, the service averaged 25 to 35 falls per month, falling to 20 to 25 per month, during 2015. For the six months in 2016 the monthly falls have fallen to five to 20 a month.</p> <p>The Health and safety team credit this reduction to a team approach that involves all aspects of staff from managers to healthcare assistants and encompassing activities staff and registered nurses.</p>
<p>Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	CI	<p>There is a well-equipped kitchen and all food is cooked on site by contracted kitchen staff. A food services manual is in place to guide staff. Registered nurses assess the dietary needs of all residents and referral to a dietitian is initiated as appropriate. The kitchen staff are informed of all dietary requirements.</p>	<p>The service identified that they needed to identify residents at risk of malnutrition and provide early intervention in order to ensure the risks associated with unintended weight loss could be minimised.</p> <p>The service introduced the 'Replenish Energy and Protein' (REAP). The action plan included training for kitchen and Onewa staff, consulting with an external dietitian and providing additional staff to assist with meals. Residents at risk of malnutrition were commenced on the REAP diet programme and weight monitored over time.</p> <p>Five residents (three rest home and two hospital) on the programme all gained weight over a period of four months. The programme has been extended for all residents at risk of malnutrition.</p>
<p>Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is</p>	CI	<p>Onewa is active in analysing data collected monthly, around infection control through the infection control team. The team reviews all infections each month and documents a report to the quality meeting. Reports include, incidence of infection, trends, training needs and individual resident follow-up.</p>	<p>The high urinary tract infection (UTI) rate for the service was an area of concern in June 2015. The IC group documented and commenced a strategy to reduce UTIs.</p> <p>UTI prevention strategies were implemented including (but not limited to) an information and training day for resident and family around causes and prevention of UTI's, training for registered nurses and all staff around UTI prevention, recognition and treatments, additional fluid rounds implemented and residents with known susceptibility had additional needs documented in care plans. Additional glasses and water carafes were purchased to ensure all residents had access to drinks at any time.</p>

undertaken. This shall be appropriate to the size and complexity of the organisation.			On evaluation of the effectiveness of these measures, they noted a drop in UTIs for the nine-month period June 2015 to March 2016 and this trend continues to decrease. Other corrective actions and strategies have been implemented where clinical indicators were high.
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End of the report.