

CHT Healthcare Trust - St Margaret's 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:	St Margaret's Hospital and Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
Dates of audit:	Start date: 29 September 2016 End date: 30 September 2016
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	85

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

St Margaret's Hospital is owned and operated by the CHT Healthcare Trust and cares for up to 88 residents requiring rest home, dementia, hospital and/or residential disability (physical) level care. On the day of the audit there were 85 residents. The service is being 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, relatives and the GP interviewed spoke positively about the service provided.

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

This audit has identified areas for improvement around care planning, wound documentation and interventions and restraint evaluations. The service has exceeded the required standard around the dementia activities and the service provided to residents at risk of weight loss.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.	Green	Standards applicable to this service fully attained.
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Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is presented to residents and their families during entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Residents and family reported that communication with management and staff is open and transparent. 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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Services are planned, coordinated, and are appropriate to the needs of the residents. A unit manager is responsible for the day-to-day operations of the facility. She is supported by a clinical coordinator/registered nurse. Quality and risk management processes are implemented. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. The health and safety programme meets current legislative requirements. Adverse, unplanned and untoward events are documented and investigated. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A staff education and training programme is embedded into practice. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Entry to the service is managed primarily by the registered nurses or clinical coordinator. There is comprehensive service information available. Initial assessments are completed by a registered nurse. Care plans and evaluations are completed by the registered nurses within the required timeframe. Care plans are written in a way that enables all staff to clearly follow their instructions. Residents and family interviewed confirmed they were involved in the care planning and review process. The documented activities programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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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 bedrooms are single occupancy and all rooms have their own ensuite. There is sufficient space to allow the movement of residents around the facility using mobility aids. The rest home/hospital areas are divided into 'suites' of eight to twelve residents, each with its own open plan lounge/dining area. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible and the dementia unit garden is secure. Cleaning contractors and maintenance staff are providing appropriate services.

Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days.

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.		Some standards applicable to this service partially attained and of low risk.
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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. The restraint coordinator is a registered nurse who is responsible for ensuring restraint management processes are followed. On the day of audit there were eight residents with restraint and one resident using an enabler.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	46	0	2	1	0	0
Criteria	2	96	0	2	1	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 Code of Health and Disability Consumers' Rights (the Code) brochures are accessible to residents and their families. The policy relating to the Code is implemented. Three managers (one area manager, one unit manager and one clinical coordinator), sixteen staff (eight healthcare assistants – six from the rest home/hospital and two from the dementia unit, three registered nurses (RN), two activities coordinators, one kitchen manager, one cleaner and one property manager) and one contracted health professional (physiotherapist) could describe how the Code is incorporated into their working environment. Staff receive training about the Code during their induction to the service. This training continues two-yearly through the mandatory staff education and training programme.</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</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their EPOA. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>Ten of ten resident files sampled (three from the dementia unit, two from the rest home and five from the</p>

and give informed consent.		hospital) had a signed admission agreement and consents.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Health and Disability advocacy brochures are included in the information provided to new residents and their family during their entry to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages their residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations. Interviews with two YPD residents confirmed that younger persons remain active in their community and participate in social activities external to the aged care facility.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and families during entry to the service. Access to complaints forms are located at reception. A record of all complaints received is maintained by the unit manager in hard copy and in an electronic database. Documentation, including follow-up letters and resolution sighted demonstrated that complaints are well-managed. Discussions with residents and families/whanau confirmed they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The staff discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident/family meetings. All ten residents (two rest home level and eight hospital level which included two younger persons with a disability (YPD)) and eleven family (seven hospital level and four dementia level) interviewed reported that the residents' rights were being upheld by the service.

<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 residents' personal belongings are used to decorate their rooms. Privacy signage is on communal toilet doors. All residents' rooms are single use with full ensuites.</p> <p>The healthcare assistants interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. All of the residents and families interviewed confirmed that the residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff attend mandatory (two-yearly) education and training on abuse and neglect, which begins during their induction to the service.</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 is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents.</p> <p>Staff education on cultural awareness begins during their induction to the service and continues as a mandatory (two-yearly) in-service. The healthcare assistants interviewed provided examples of how they ensure Māori values and beliefs are upheld by the service. There were no residents living at the facility who identified as Māori during the audit.</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 identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the residents' care plans, evidenced in all ten care plans reviewed (two rest home, three dementia and five hospital). Residents and family interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>
<p>Standard 1.1.7:</p>	FA	<p>Professional boundaries are discussed with each new employee during their induction to the service.</p>

<p>Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>Professional boundaries are also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the healthcare assistants' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Good practice was evident. A registered nurse is available 24 hours a day, seven days a week. A general practitioner (GP) visits the facility two times a week. Residents are reviewed by a general practitioner (GP) every three months at a minimum.</p> <p>Residents and family/whānau interviewed reported that they are either satisfied or very satisfied with the services received. A resident/family satisfaction survey is completed annually and confirmed high levels of satisfaction with the services received.</p> <p>The service receives support from the district health board (DHB) which includes (but is not limited to) specialist visits. Physiotherapy services are available eight hours per week. A van is available for regular outings. Areas of continuous improvements were identified around the activities programme in the dementia unit and the food and nutrition programme.</p> <p>The GP interviewed is satisfied with the care that is being provided by the service.</p> <p>Examples of good practice evidenced at CHT St Margaret's were: (i) Utilisation of adverse event reports to inform practice for continuous improvement. (ii) The activities programme has been enhanced for all residents for a better quality of life. (iii) Strong relationships with hospice, the local community and word of mouth resulting in high occupancy. (iv) The low staff turnover provides continuity of care for residents. (v) Provision of Skills for Work support for staff to assist with completion of ACE training.</p> <p>And (vi) Strong connections with the community with regular visits from a kindergarten, library groups and church groups.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	<p>FA</p>	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The policy also describes that open disclosure is part of everyday practice. The care staff interviewed understood about open disclosure and providing appropriate information and resource material when required.</p> <p>Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Fifteen accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.</p>

communication.		An interpreter service is available and accessible if required through the DHB. Families and staff are utilised in the first instance.
<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>	FA	<p>St Margaret's Hospital is owned and operated by the CHT Healthcare Trust. The service provides rest home, dementia, hospital and residential disability (physical) level care for up to 88 residents. Sixty-eight beds are dual-purpose, for rest home and hospital level care, and 20 beds are dedicated dementia beds.</p> <p>Eighty-five residents were living at the facility during this audit. This included seven rest home residents, fifty-eight hospital level residents and twenty residents in the secure dementia unit. Four of the residents (three hospital level and one rest home level) were on the YPD contract, and one resident (hospital level) was funded by ACC.</p> <p>The unit manager is a registered nurse (RN) who has been in this role for two years. She has 21 years of management experience in both the disability and private sectors. She is supported by a clinical coordinator/RN that has been in her role for two months and has been working at the facility for the past two years. The unit manager reports to the CHT area manager who reports to the CEO.</p> <p>CHT has an overall business/strategic plan, philosophy of care and mission statement. The annual facility-specific business plan links to the organisation's strategic plan and is reviewed monthly with the CEO.</p> <p>The unit manager has completed a minimum of eight hours of professional development relating to the management of an aged care service over the past twelve 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>	FA	In the absence of the unit manager, the clinical coordinator oversees the management of the facility with support from the area manager and staff RNs.
Standard 1.2.3: Quality And Risk Management	FA	A quality and risk management programme is in place. Interviews with the managers and staff reflected their

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>understanding of the quality and risk management systems that have been put into place.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures have been updated to include reference to InterRAI, health and safety and pressure injury management. New policies or changes to policy are communicated to staff, evidenced in meeting minutes.</p> <p>Data collected (eg, falls, medication errors, wounds, skin tears, complaints, infections) are collated and analysed with results communicated to staff in the quality/health and safety (staff) meetings and the RN meetings, evidenced in the meeting minutes. Results are also posted in the staff room for staff to view.</p> <p>Internal audits are completed six-monthly by the area manager. Areas of non-compliance include the initiation of a corrective action plan with sign-off by the area manager when implemented.</p> <p>A health and safety programme is in place. CHT facilities have been awarded tertiary level workplace safety management practice (WSMP) certificate (expiry July 2017). An interview with four health and safety representatives (two healthcare assistants, one receptionist, one unit manager) and review of health and safety documentation confirmed that legislative requirements are being met.</p> <p>Falls prevention strategies include a comprehensive investigation of residents' falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. The facility has purchased beds that can be lowered to low levels, and sensor mats. Hip protectors are used to prevent injuries from falls.</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>	<p>FA</p>	<p>An accidents and incidents reporting policy is in place. Adverse events are linked to the quality and risk management programme. There was evidence to support actions are undertaken to minimise the number of incidents. Clinical follow-up of residents, conducted by a registered nurse, was evidenced in all fifteen accident/incident forms selected for review.</p> <p>Discussions with the unit manager and clinical coordinator confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. This has not been required since their last (surveillance) audit.</p>
<p>Standard 1.2.7: Human</p>	<p>FA</p>	<p>There are human resource management policies in place which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity,</p>

<p>Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>evidenced in all nine staff files reviewed (six healthcare assistants, one registered nurse, one clinical coordinator, one activities coordinator).</p> <p>Copies of practising certificates are kept on file. The service has implemented a general orientation programme that provides new staff with relevant information for safe work practice. Evidence of completed induction checklists were sighted in all nine staff files. Annual staff appraisals sighted were up-to-date.</p> <p>An in-service education programme is being implemented. Regular in-services are provided by a range of in-house and external speakers including but not limited to nurse specialists, Aged Concern and the Health and Disability Advocacy Service. All eight HCAs who have been working regularly in the dementia unit for longer than one year have completed their Aged Care Education (ACE) dementia qualification.</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 to manage the care requirements of the residents. At least one registered nurse is on site at any one time. Three registered nurses are on morning shift, two on a full afternoon shift and one on a short afternoon shift and one overnight. The registered staff provide cover in the dementia unit. Activities staff are available seven days a week. 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> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked area.</p> <p>Residents' files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant healthcare assistant or health professional, and include their designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable,</p>	FA	<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. Dementia residents and their family receive specific information relating to the dementia unit. 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. The admission agreement form in use aligns with the requirements of the</p>

<p>timely, and respectful manner, when their need for services has been identified.</p>		<p>ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</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. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</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. Rest home and hospital residents have their individual medications (unless they require refrigeration) stored in a locked drawer in each residents room. The drawer can only be accessed by staff designated to administer the medications. Medications are stored in a locked cupboard in the dementia unit office. Medication administration practice complies with the medication management policy for the medication rounds sighted. Medication prescribed is signed as administered on the electronic medication documentation system. Registered nurses administer medicines. All staff that administer medication are competent and have received medication management training. The RN on duty reconciles the delivery and documents this. Medication charts are documented in the electronic medication system by the prescribing doctors. The system had only been active for one week prior to the audit so all medications were newly documented. For the 20 medication charts reviewed electronically all documentation met legislative requirements and relevant guidelines. No residents currently self-administer medicines.</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</p>	<p>FA</p>	<p>There is a fully functional kitchen and all food is cooked on site by contracted kitchen staff. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who need special diets and the kitchen manager works closely with the RNs on duty. The kitchen staff have completed food safety training. The kitchen manager and cooks follow a rotating seasonal menu which is currently in the process of review by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members</p>

delivery.		interviewed were very happy with the quality and variety of food served. The service has exceeded the standard around meeting the specific dietary needs of dementia residents.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service records the reason for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools were completed and assessments were reviewed at least six monthly or when there was a change to a resident's health condition in files sampled. The InterRAI assessment tool is implemented. Care plans are developed on the basis of these assessments (link 1.3.5.2).
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	Three of the ten long-term care plans reviewed described the support required to meet the resident's goals and needs. All ten care plans identified allied health involvement under a comprehensive range of template headings. Residents and their family/whānau are involved in the care planning and review process. All care plans sampled had been signed by the resident and/or a family member. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and	PA Moderate	Food and fluid charts, staff interviews, observation of staff and equipment and progress notes charts sighted indicate that appropriate interventions are provided, despite not all interventions being clearly outlined in care plans. Two resident files sampled had shifts where the turning chart had not been completed and one resident requiring a weekly BP for two weeks had not had this documented. Registered nurses (RNs) (including the

<p>appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>clinical coordinator) and healthcare assistants report progress against the care plan each shift. If external nursing or allied health advice is required the RNs will initiate a referral (eg, to the district nurse). If external medical advice is required this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Wound monitoring was in place for 12 residents with 19 wounds (11 skin tears, one surgical wound, two skin cancers, two ulcerated areas, one ulcer, and one laceration). There were no pressure injuries at the time of the audit. Not all wounds had comprehensive assessments and management plans. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>Interviews with registered nurses, clinical coordinator and healthcare assistants demonstrated an understanding of the individualised needs of residents and report that two hourly turns occur. Food and fluid charts are comprehensively completed as required.</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>	<p>CI</p>	<p>Three activities coordinators are employed (one full time and two part time) to operate the activities programme for all residents over seven days. Two of the three activities coordinators are trained diversional therapists. Healthcare assistants also provide activities in the dementia unit. The activities programme has been reviewed and the service has exceeded the required standard around activities provided in the dementia unit. Each resident has an individual activities assessment on admission and from this information an individual activities plan is developed as part of the care plan by the registered nurses with input from the activities staff. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. All long-term resident files sampled have a recent activities plan within the care plan and this is evaluated at least six monthly when the care plan is evaluated. Plans sampled in the dementia unit document activities to support the resident over the 24 hour period and each resident in the dementia unit now has a 24 hour care plan on the wall in their room to provide quick reference for visitors and staff. Younger residents are encouraged to remain as active as possible within the community and to engage in age appropriate personal interest activities. Residents and families interviewed commented positively on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>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. Changes in health status were documented and followed up with one exception (link 1.3.5.2). Care plan reviews are signed by an RN. Resident files sampled demonstrated that short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>

comprehensive and timely manner.		
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>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>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Interviews and medical notes demonstrate that referrals and options for care were discussed with the family. The staff provided examples of where a resident's condition had changed and the resident was reassessed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety datasheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for</p>	FA	<p>The building has a current building warrant of fitness. There is a full-time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. The external area is well maintained. The service has recently contracted specific gardening staff to provide a more pleasant environment for residents. The dementia unit garden is interesting, large and secure. 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>

their purpose.		
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. All resident rooms have their own ensuites. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The rest home/hospital area is divided into seven 'suites', each with an individual open plan lounge/dining area. Additionally there is a large communal lounge. The dementia unit has two lounges, a quiet area and a dining area and an activities project area is being developed.</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 facility is cleaned by contracted cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All laundry is done off site. Residents and relatives interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months at a minimum. The orientation programme and mandatory education and training programme include fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water, and blankets. A gas barbeque is available.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. Call bells are checked monthly by maintenance staff.</p> <p>There is a minimum of one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>St Margaret's Hospital has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The clinical coordinator (a registered nurse) is the designated infection control coordinator with support from the unit manager and all staff as the quality management committee (infection control team). Minutes are available for staff. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</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>	<p>FA</p>	<p>The clinical coordinator at St Margaret's Hospital is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<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</p>	<p>FA</p>	<p>There are CHT infection control policies and procedures appropriate to 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>

are practical, safe, and appropriate/suitable for the type of service 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	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.
<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	Infection surveillance is an integral part of the infection control programme and is described in CHT's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the unit manager. There have been no outbreaks since the previous audit.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	There are policies around restraints and enablers. Eight residents (hospital level) were using restraints and one resident was using an enabler. Appropriate assessment and consent processes were completed for the one resident (YPD at hospital level) using a lap belt as an enabler. Staff receive mandatory training around restraint minimisation. All care staff interviewed understood the difference between an enabler and a restraint.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including</p>	FA	A restraint approval process and a job description for the restraint coordinator are in place. Restraint minimisation policies and procedures describe approved restraints. A registered nurse is the designated restraint coordinator. Restraint minimisation has been a focus in the quality/health and safety meetings. A healthcare assistant has been appointed to the restraint team to show the healthcare assistant staff how to correctly document and monitor restraint use.

<p>policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The restraint coordinator is responsible for assessing a resident's need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. Assessment tools are in place for restraints and enablers.</p> <p>Two hospital level residents' files where restraint was being used were selected for review. Each file included a restraint assessment and signed consent. The restraint assessment addresses risks associated with restraint use. This information is linked to the resident's care plan.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>A monthly restraint register is being implemented. The register identifies the residents that are using a restraint, and the type of restraint used. Eight residents were listed on the register. Types of restraints used included bed rails and lap belts.</p> <p>The restraint assessments reviewed identified that restraint is being used only as a last resort. The restraint assessment process includes determining the frequency of monitoring while restraint is in use. RNs have been updated on restraint procedures and documentation requirements and take responsibility at each shift to ensure restraint monitoring is correctly documented.</p> <p>Monitoring forms for both residents were completed and included when the restraint was put on and when it was taken off.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>PA Low</p>	<p>Restraint use is scheduled to be reviewed on a CHT restraint assessment and consent evaluation form six-monthly (at a minimum). The restraint coordinator is new to her role and was unaware of the CHT evaluation process. The evaluation of restraint use for the two files selected was last completed in December 2015. A monthly restraint report is completed by the restraint coordinator and is signed off by the unit manager each month. This report is discussed at each (monthly) RN meeting.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The area manager meets at least annually with the restraint coordinators from all CHT sites to review restraint minimisation procedures and practice. All care staff have an individual record of education in restraint minimisation and safety practice. This is a two-yearly mandatory training requirement.</p>
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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 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	<p>One resident with complex needs did not have these all documented in the care plan (link hospital tracer). However staff were clearly able to describe interventions required and there was evidence that the cares, although not documented in some files were known to staff and being implemented. The care planning issue is therefore a documentation issue and assessed as low risk.</p>	<p>Six of ten resident files (three hospital and three from the dementia unit) had identified issues that were not documented in the long-term care plan. One resident (hospital level) did not have a short-term care plan developed</p>	<p>Ensure all identified needs are documented on a care plan.</p> <p>60 days</p>

			on return from hospital.	
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Turning charts sampled, had shifts where they had not been completed (interview of these staff confirmed the turns had occurred and the residents confirmed this). All wounds had either a wound assessment or a wound management plan, but only two wounds had both. One resident had recent evidence of weekly and daily blood pressure readings as ordered by the GP but weekly blood pressure checks had not been documented recently.</p>	<p>(i) Thirteen wounds did not have a comprehensive assessment and four wounds did not have a documented wound management plan.</p> <p>(ii) Two turning charts (hospital level) had occasions where they had not been completed.</p> <p>(iii) One resident (rest home level) requiring weekly blood pressure readings had not had these documented for the previous two weeks.</p>	<p>(j) Ensure every wound has a comprehensive assessment and a wound management plan.</p> <p>(ii) Ensure that turning charts are documented when completed.</p> <p>(iii) Ensure that the GPs instructions are followed.</p> <p>30 days</p>

<p>Criterion 2.2.4.1</p> <p>Each episode of restraint is evaluated in collaboration with the consumer and shall consider:</p> <p>(a) Future options to avoid the use of restraint;</p> <p>(b) Whether the consumer's service delivery plan (or crisis plan) was followed;</p> <p>(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);</p> <p>(d) Whether the desired outcome was achieved;</p> <p>(e) Whether the restraint was the least restrictive option to achieve the desired outcome;</p> <p>(f) The duration of the restraint episode and whether this was for the least amount of time required;</p> <p>(g) The impact the restraint had on the consumer;</p> <p>(h) Whether appropriate advocacy/support was provided or facilitated;</p> <p>(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;</p> <p>(j) Whether the service's policies and procedures were followed;</p> <p>(k) Any suggested changes or additions required to the restraint education for service providers.</p>	<p>PA Low</p>	<p>Restraint evaluation forms cover the criteria listed (a) – (k). The restraint coordinator, new to her role, was unaware of the CHT restraint evaluation process.</p>	<p>Restraint use is scheduled to be evaluated six-monthly (at a minimum). Two residents' files reviewed indicated that the evaluations for both residents were last completed in December 2015.</p>	<p>Ensure the use of restraint is evaluated as per CHT policy.</p> <p>90 days</p>
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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 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	CI	The service works actively with the contracted kitchen team to ensure that all residents' nutritional needs are addressed. Programmes are developed to address issues identified. These include the REAP (Replenish, Energy and Protein) programme which includes fortifying foods usually eaten by residents for residents who are at risk of weight loss. The emphasis is on food first rather than commercial supplements for managing unintended weight loss. Additionally a finger food programme has been initiated to meet the specific needs of	CHT St Margaret's identified that malnutrition resulting in serious deterioration of health is a risk for dementia residents. A project was developed to reduce this risk. The service aims to provide nourishing finger foods at meal and snack times to prolong independence in eating, thereby supporting independence, self-esteem and dignity. Finger foods and everyday foods are adapted so they can be easily picked up and eaten by hand. The menu has been specifically designed and the finger foods deliver a high concentration of nutrients in a small volume of food. This is not party food or sandwiches. The programme commenced in March 2016 and went live on 11 May 2016. A review of weight records for four residents on the programme identified weight stabilisation or weight gain for each resident.

		dementia residents.	
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The service provides a varied activities programme over seven days. A new activities team has reviewed and amended the activities programme for the entire facility with positive feedback. All residents in the dementia unit have had individual activities in which they engage and which they enjoy documented and these are now implemented by healthcare assistants.</p>	<p>In 2015, following a seeming lack of engagement in activities by residents in the dementia unit the service determined to improve the delivery of activities to better meet the resident's needs. Staff were recruited to the activities coordinator roles that have relevant qualifications – two diversional therapists and one trained teacher with experience in the health sector. The mix of activities staff included two younger women and one more mature lady to meet different needs of different residents. Twenty-four hour activity plans were completed for all sunflower suite (dementia) residents and placed on the wall in individual rooms for easy reference by all staff at all times of the day. All healthcare assistants have been encouraged to be involved in activities and take responsibility for getting their residents to engage in activities with training, ideas and oversight provided by the activities coordinators. As a result of these actions every resident file sampled in the dementia unit (six around activities) documented each resident being involved in a minimum of four activities every day. Previously there were often days when some residents did not specifically engage in any activities as demonstrated in the resident files.</p>

End of the report.