# CHT Healthcare Trust - Carnarvon Private Hospital

## Introduction

This report records the results of a Certification Audit; Partial Provisional 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** CHT Healthcare Trust

**Premises audited:** Carnarvon Private Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 23 August 2017 End date: 24 August 2017

**Proposed changes to current services (if any):** This audit has assessed all 40 previously hospital level care only rooms as appropriate to be used for either rest home or hospital level care.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 30

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

## General overview of the audit

Carnarvon Hospital is owned and operated by the CHT Healthcare Trust and provides care for up to 40 residents requiring hospital (geriatric or medical) level care. On the day of the audit, there were 30 residents.

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

In addition to the certification audit, a partial provisional audit was conducted to assess the preparedness of the service to provide rest home level of care. This audit has assessed that the service is suitable to provide rest home level care in any of the 40, current hospital only beds, (to make them dual-purpose).

A unit manager, who is well qualified and experienced for the role and is supported by a charge nurse (on leave at the time of the audit) and the area manager, is overseeing the service. Residents, relatives and the GP interviewed spoke positively about the service provided.   
This audit has identified areas for improvement around analysing quality data for trends, completion of neuro observations, making essential notifications, staff training, assessments, care planning and aspects of medication management.

## 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. |

Care is provided in a way that ensures 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. Family are involved in the initial care planning and provided with ongoing feedback. Regular contact is maintained with family, including if an incident/accident or a change in resident’s health status occurs. Information on informed consent is included in the admission agreement and is discussed with residents and relatives. The service has documented complaints and there is evidence of follow-up. The complaints register reviewed, included verbal and written complaints and all sighted complaints are well managed.

## Organisational management

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

Carnarvon has a current business plan and a documented quality assurance and risk management programme that outlines objectives for the next year. The quality process includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management.

Residents and relatives are provided with the opportunity to feedback on service delivery issues at monthly resident meetings and via satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Carnarvon has job descriptions for all positions that include the role and responsibilities of the position. Staff are supported to undertake external training. The service has a documented rationale for determining staffing and healthcare assistants, residents and family members report staffing levels are sufficient to meet resident needs.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

There is a welcome pack that contains comprehensive information on the services available at CHT Carnarvon. Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information gained through the discharge summaries, interRAI assessments, care plans and evaluations 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 DT and HCAs 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.

## Safe and appropriate environment

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| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The building has a current warrant of fitness and emergency evacuation plan. There is a reactive and planned maintenance programme in place. Chemicals are stored safely throughout the facility. All resident rooms are single with the exception of four double rooms. There is a mix of ensuites and communal toilet/shower facilities. 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 can 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 other emergency. There is a first aider on duty at all times. Laundry is outsourced.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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. |

A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers aligns with the definition in the standards. There is a restraint register and a register for enablers. There were seven residents requiring restraints and four residents using enablers. Staff are trained in restraint minimisation and challenging behaviour management. Processes are implemented around assessment, monitoring and evaluation.

## Infection prevention and control

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| --- | --- | --- |
| 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 evidenced 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.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 43 | 0 | 5 | 2 | 0 | 0 |
| **Criteria** | 0 | 93 | 0 | 6 | 2 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with staff (six healthcare assistants (HCAs), one registered nurse (RN), the diversional therapist, one area manager and one unit manager) confirmed their familiarity with the Code. Interviews with eight residents and two relatives confirmed the services being provided are in line with the Code. The Code is discussed at resident and staff/quality meetings. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Six resident files reviewed (two hospital (geriatric), one hospital (medical), one younger person, one resident under ACC funding and a respite care resident) demonstrated that advanced directives are signed for separately. There was evidence of discussion with family when the GP had completed a clinically indicated not for resuscitation order. Six healthcare assistants (HCAs) and one registered nurse (RN) interviewed, confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative’s lives. All six resident files reviewed including the respite care resident, had a signed admission agreement. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff, residents and relatives informed they are aware of advocacy and how to access an advocate. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are encouraged to be involved in community activities and maintain family and friend’s networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. On interview, all residents and relatives confirmed this and that visiting could occur at any time. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. There is a complaint’s form available. Information about the complaints process 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.  There is a complaint’s register. The one complaint received since CHT commenced operating the service was reviewed. The complaint had noted investigation, timelines, corrective actions and resolutions including a meeting with the complainants and a follow-up written response documented. Discussions with residents and relatives confirmed that any issues are addressed and they feel comfortable to bring up any concerns. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There are posters of the Code on display throughout the facility and leaflets are available in the foyer. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or EPOA to read with the resident and discuss. On entry to the service an RN or the unit manager discusses the information pack with the resident and the family/whānau. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident’s privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met.  There is a policy that describes spiritual care. Church services are conducted in the facility every week. All residents and relatives interviewed indicated that residents’ spiritual needs are being met when required.  Staff interviewed described appropriate processes to reduce the risk of abuse and neglect, and to identify and report this if it were suspected. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. Staff training includes cultural safety. The service is able to access Māori advisors as identified in the Māori health plan and policies.  Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. Discussions with staff confirm that they are aware of the need to respond to cultural differences. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service has established cultural policies aimed at helping to meet the cultural needs of its residents. All residents and relatives interviewed, reported that they were satisfied that their cultural and individual values were being met.  Information gathered during assessment, including resident’s 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. The staff come from a variety of cultural backgrounds, which are reflective of the residents and assists in meeting resident cultural needs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect process covers harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has policies to guide practice that align with the health and disability services standards to meet the needs of residents requiring hospital level of care. Staffing policies include pre-employment and the requirement to attend orientation and an ongoing in-service training plan (link 1.2.7.5). The resident satisfaction survey reflects high levels of satisfaction with the services that are provided. Residents and relatives interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and state that they feel supported by the management team.  The service has a particular expertise in the care, support and management of people who have experienced a stoke and receive a high number of referrals for such residents. Evidence was provided of residents referred for long-term care who were not expected to further improve when discharged from DHB service that had been rehabilitated at Carnarvon, to a point where they were discharged home. Others had become mobile or had gained independence in areas such as eating and ADLs. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Nine incident/accident forms were sampled. The form includes a section to record family notification. All nine forms indicated family were informed or if family did not wish to be informed. Relatives interviewed, confirmed they are notified of any changes in their family member’s health status. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Carnarvon has been owned and operated by the CHT Healthcare Trust since November 2016. The service provides hospital level care for up to 40 residents. On the day of the audit there were 30 residents. This included four residents on younger persons with disabilities (YPD) contracts, one resident on respite care, one resident funded by ACC and one resident on a palliative care contract. This audit has assessed the 40 previously hospital level beds as suitable for use for either hospital or rest home level residents (dual-purpose). The service understands the needs of rest home level residents and have provided for their greater independence and ability to connect with the community.  The unit manager is a registered nurse and maintains an annual practicing certificate. He has significant experience in DHB aged care services and management. He has been in the role for six weeks prior to CHT purchasing the facility. He is supported by a charge nurse (on annual leave during the audit) and competent registered nurses. The unit manager reports to the CHT area manager weekly on a variety of operational issues. CHT has an overall business/strategic plan and Carnarvon Hospital has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement. The unit manager has completed in excess of eight hours of professional development in the past 12 months.  Partial provisional: The current business plan includes goals and actions to transition to providing rest home level care. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of the unit manager, the area manager is in charge, with support from the senior management team, the (currently acting) charge nurse and care staff. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | There is an organisational business/strategic plan that includes quality goals and risk management plans for CHT Carnarvon. There is evidence that the CHT quality system is being implemented at the service. The unit manager advised that he is responsible for providing oversight of the quality programme. The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies are suitable for both hospital and rest home level care and are reviewed at national level with input from facility staff every two years. New/updated policies are sent from head office. Staff have access to manuals.  Resident/relative meetings are held regularly and previous issues raised are addressed at the beginning of each meeting.  Data is collected in relation to a variety of quality activities and a comprehensive internal audit has been completed by the area manager. Areas of non-compliance identified through quality activities are actioned for improvement. Data is collected around accidents and incidents, complaints, infections and restraint use. Carnarvon has recently started entering this data into the electronic database which will provide trends around these areas. At the time of the audit there was no evidence that data had been analysed for trends, and therefore that information about trend analysis had been provided to staff. The service has changed in April 2017 from having separate meetings for registered nurses, caregivers, health and safety and quality to having one combined quality/health and safety meeting that includes infection control and to which all staff are invited.  Residents have been surveyed on a rotating basis with a sample of residents/families being surveyed each month. The sample is determined by the month of the resident’s birthday. Collated results to date (noting the service has not yet been operating under CHT for a full year) show 100% satisfaction with the care provided and 100% of those surveyed would recommend the service to others.  The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The unit manager is the designated health and safety person and health and safety issues are addressed in the monthly quality/health and safety meetings.  Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Low | There is an accidents and incidents reporting policy.  Advised that the unit manager investigates accidents and near misses and analysis of incident trends occurs.  There is a discussion of incidents/accidents at monthly quality/health and safety meetings (link 1.2.3.6).  Nine incident forms that were sampled (all incidents for July 2017) and all documented clinical follow-up of residents by a registered nurse. Incident forms documented that neuro observations had been completed for residents with a potential head injury but documentation to support this was not available. Pressure injuries were noted not to have been documented on incident reports.  Discussions with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. One incident of a resident assaulting another resident had been reported to HealthCERT. This resident had been comprehensively assessed by the DHB mental health team following the incident and at the time of the audit the DHB were providing one-to-one monitoring of this resident. Two pressure injuries have also been reported to HealthCERT. A resident and a family member made a serious allegation against a staff member to police in January 2017. The staff member did not attend work until the complaint was resolved and for a period after this. The police formally closed the investigation as comprehensively unsubstantiated nine days after the complaint was made. The resident has since been discharged. This incident was not reported to HealthCERT. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Moderate | There are human resource management policies in place, which include 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. Five staff files were reviewed (two registered nurses, two healthcare assistants and the activities coordinator) and evidenced that reference checks were completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. CHT has a documented in-service programme but this is not being implemented at Carnarvon. The unit manager, registered nurses and healthcare assistants are able to attend external training including sessions provided by the local DHB. Two of the five RNs are interRAI trained. The service has not yet been under CHT for one year so performance appraisals were not yet due.  Partial provisional: Staff employed have the skills to support rest home level residents. However, not all required training has been provided. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | CHT policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The facility manager (a registered nurse) is on duty from Monday to Friday and on call. At least one registered nurse is rostered on at any one time and all registered nurses have a current first aid certificate. Advised that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identify that staffing is sufficient to meet the needs of residents.  Staffing (care staff) at the time of the audit (for 30 hospital level residents) was:  Morning shift: One RN on a full shift and a second until 1 pm, five healthcare assistants on a full shift and two until 12.00pm  Afternoon shift: One registered nurse, three healthcare assistants on a full shift and one from 3 – 9 pm.  Night shift: One registered nurse and two healthcare assistants.  Partial provisional: The current staffing is sufficient to meet the needs of rest home level residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being locked away in the nurses’ stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication records are stored separately. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The unit manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the unit manager or RN. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require admission to hospital are managed appropriately and relevant information is communicated to the DHB. Relatives are notified if transfers occur. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | The medication management policies and procedures comply with medication legislation and guidelines. Medicines are stored safely. The service uses an electronic medications system. Registered nurses are responsible for medication administration and complete annual medication competencies. Registered nurses have completed syringe driver competencies. Robotic medication rolls are checked on delivery by the RN on duty. There is an imprest stock, however, there were some medications that had expired. Eyedrops are dated on opening. There are no standing orders. There were no residents self-medicating on the day of audit. The medication fridge temperature is monitored daily,  Twelve medication charts on the electronic medication system were reviewed. All charts met prescribing requirements including the indication for use of ‘as required’ medications. All charts had photo identification and allergy status.  Partial provisional:  The currently implemented medication system is satisfactory to meet the needs of rest home level residents. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals and baking is done on-site by a contracted service. The qualified Monday to Friday cook is supported by a weekend cook and kitchen assistants. The four-weekly four seasonal menus have been reviewed by a dietitian. The cook receives resident dietary profiles for all residents and notified of any changes such as weight loss. Resident dislikes are known and accommodated. Modified diets including pureed/mince moist, diabetic and vegetarian meals are provided. Meals are plated, covered and transported in scan boxes to the two dining rooms. There is specialised crockery and cutlery for use as required.  The kitchen staff have completed food safety training. The temperatures of refrigerators, freezers and end cooked foods are monitored and recorded. All food is stored appropriately. Residents interviewed were satisfied with the quality and variety of food served.  Partial provisional:  The current food service is satisfactory to accommodate all rest home resident dietary requirements. |
| 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 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. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | Resident files reviewed indicated that all appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. Four of six files reviewed contained applicable risk assessment tools and these assessments were reviewed at least six-monthly or when there was a change to a resident’s health condition. The interRAI assessments have been completed for the long-term residents and care plans were developed based on these assessments. Additional assessments for management of behaviour and wound care were completed according to need. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | Long-term care plans for permanent residents had been completed within three weeks. Not all long-term care plans reflected the resident’s current needs/supports. The respite care plan was not current. 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 process. Short-term care plans are in use for short-term needs including infections. Short-term care plans are evaluated regularly and either resolved or if an ongoing problem, transferred to the long-term care plan. Care plans identified allied health input into the resident’s care including the dietitian, speech language therapist, hospice nurse, podiatrist, physiotherapist, specialist wound care nurse, gerontology nurse and the mental health team. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Registered nurses (RNs) and healthcare assistants (HCAs) follow the care plan (link 1.3.5.2) and report progress against the care plan each shift at handover. If a resident’s condition changes the RNs will initiate a GP or nurse specialist referral.  Staff have access to sufficient medical supplies and 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.  Wound assessment, wound monitoring, and wound evaluations are in place for seven wounds including two community acquired pressure injuries. Documentation and photos monitor healing progress. The wound nurse specialist has been involved with the management of the pressure injuries.  There was evidence of monitoring a resident’s health status such as two hourly turning charts, food and fluid charts, regular monitoring of bowels, monthly weights, blood pressure, blood sugar levels, behaviour, pain and restraint monitoring as required. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service employs a qualified diversional therapist (DT) who graduated in February 2017 and has been with Carnarvon private hospital for 13 years as an HCA. The DT coordinates and implements a Monday to Friday programme 9.00am to 3.30pm in the two activity lounges. In one lounge, there are meaningful one-on-one activities for those residents less physically able. There is an HCA in the activity lounge from 7.00am to 12.30pm. The DT runs a programme in the larger lounge/dining room for the more able residents. There are integrated activities that include fortnightly church services, weekly entertainment, monthly story-teller, happy hour and movies. There is a volunteer who assists with arts, games and housie and a student social worker volunteer. All the residents have an opportunity for outings that occur weekly. The service hires a mobility vehicle that safely accommodates hospital comfort chairs and wheelchairs. Outings include drives to beaches, parks and museums. There are outings into the community such as the Tui Glen Neurology group exercise programme, weekly visits to Alzheimer’s coffee group and events, RSA and visits to other CHT facilities. The canine therapy group visit fortnightly.  The DT spends one-on-one time with the younger persons to ensure their interests and hobbies are maintained, including available internet use, newspapers and printing of their photos. They are supported to attend community interest groups.  A lifestyle questionnaire is completed soon after a resident’s admission. An individual activities plan is developed for each resident and reviewed six-monthly in consultation with the resident and RN. Participation is monitored. Residents can feedback on the activity programme through resident meetings and surveys.  Partial provisional:  The DT and HCAs currently provide separate activities for higher functioning residents and have the resources to expand further for rest home level residents. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Initial care plans reviewed had been evaluated by the registered nurses within three weeks of admission. The long-term care plans were evaluated at least six-monthly or earlier for health changes in all files reviewed. There is a three-monthly multidisciplinary review that includes input from the resident (if appropriate), RN, HCAs, GP, pharmacist, physiotherapist and any other relevant health professionals involved in the care of the resident. The family are invited to attend and are sent a copy of the review if unable to attend. The written evaluations record the residents progress against the resident goals. The care plans are updated to reflect changes identified during the review (link 1.3.5.2). |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other medical and non-medical services. 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 were sighted on the files reviewed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. There are three sluice rooms (two with chemicals). 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. There is no decanting of chemicals. Safety datasheets are readily available. There is a chemical spills kit available.  Partial provisional:  The current systems for managing waste and hazardous substances is satisfactory to meet the needs of rest home level residents. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires 13 July 2017. The building is one level. The maintenance person was on leave and was being covered by a relieving maintenance person (interviewed) from another CHT site, who was available for more urgent repairs as observed on the day of audit.  A maintenance and repairs communication log is maintained and demonstrates maintenance and repairs are addressed within a timely manner. There is a planned maintenance schedule in place. Monthly hot water temperature checks of are completed and are below 45°C. Essential contractors are available 24 hours. Equipment has been tested and tagged and clinical equipment calibrated.  The facility has sufficient space and wide corridors for residents to mobilise using mobility aids and electric chairs. External areas are well maintained. Residents have safe ramp access to external areas that have seating and shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.  Partial provisional:  The facility has sufficient space for residents to mobilise safely with safe access to the external areas and suitable for rest home level residents. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All resident rooms have hand basins. Three rooms have ensuite toilets. There are sufficient numbers of large communal toilets and showers with privacy signs. Privacy curtains are in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.  Partial provisional:  There are three rooms with ensuites and adequate numbers of communal toilets/showers to meet the needs of rest home level residents. There is a new building under construction with full ensuites for all rooms. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There are 36 single rooms and four double rooms. Currently all rooms have single occupancy. There is the provision for privacy curtains in double rooms. The rooms are of an appropriate size to be able to provide for hospital level of care residents. Residents can safely move about the room with the use of mobility aids and there is sufficient space for the use of hoists for the safe transfer of residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit  Partial provisional:  The large hospital level rooms are spacious enough for rest home level of care. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The communal areas include a lounge/dining area in one wing and a large lounge in the second wing that can be closed off into two separate lounges. There is a large dining area also, which is large enough to cater for activities and entertainers as observed on the day of audit. 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 for visitors.  Partial provisional:  The communal areas are suitable and easily accessible to meet the needs of rest home level residents. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Dedicated 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 datasheets are available.  All laundry is completed off-site and picked up and delivered daily. There are separate entry/exit doors for the pickup and delivery of laundry. There is a washing machine (tested and tagged) available for delicate clothing if required. Laundry equipment has been tested and tagged.  Partial provisional:  The cleaning and laundry service meets the needs of all residents, thereby able to meet the needs of rest home level residents. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | A fire evacuation plan is in place that has been approved by the New Zealand Fire Service June 2000. 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. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, torches and gas cooking. Short-term back-up power for emergency lighting is in place. A generator is available through the hire centre.  A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. There are call bells in the residents’ rooms and communal areas. Residents were observed to have call bells within reach or an HCA observing residents.  There is security lighting at night and access to the building is by bell.  Partial provisional:  The emergency management systems in place are satisfactory to meet the needs of rest home level residents. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | There is underfloor heating throughout the facility. All rooms have external windows that open, allowing plenty of natural sunlight. There is plenty of natural light in the communal areas. Residents and relatives reported the temperature was comfortable.  Partial provisional:  The corridors, rooms and communal areas are heated by underfloor heating and suitable to meet the needs of rest home level residents. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Carnarvon Hospital is beginning to embed the CHT infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A senior 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. An internal audit has been conducted and includes hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has not been operating for a full year. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | A senior registered nurse at Carnarvon 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 coordinator and IC team (comprising all staff) have good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are CHT infection control policies and procedures appropriate 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. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred (July 2017). The infection control coordinator has completed on line infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in CHT’s infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data has recently begun being entered into the CHT database but was not being analysed for trends by the time of the audit (link 1.2.3.6). Infection control is 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 provisional audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. There were seven residents with restraint and four residents with an enabler. Enabler use is voluntary. Not all necessary documentation has been completed in relation to the restraints (link 1.3.5.2 and 2.2.2.1). Staff interviews and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP) and enabler usage. 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. The unit manager (registered nurse) is the designated restraint coordinator. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The unit manager is the restraint coordinator. Assessment (link 2.2.2.1) and approval processes for restraint use included the restraint coordinator, registered nurses, resident or representative and medical practitioner. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | PA Low | The service has comprehensive assessment forms for residents who require restraint or enabler interventions. These were not being used. Decisions around restraint use are made in partnership with the family/whānau in the two files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment (completed verbally) and consent process. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The restraint minimisation manual identifies that restraint is put in place only where it is clinically indicated and justified and approval processes. An assessment process is completed for all restraints and enablers (link 2.2.2.1). The files reviewed did not all have a care plan that reflected risk (link 1.3.5.2). Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the two restraint files reviewed. The service has a restraint and enablers register, which is updated each month. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The service has documented evaluation of restraint every six months as part of the MDT review at which family are present. In the restraint files reviewed, evaluations had been completed by the restraint coordinator seven days after the implementation of restraint, as both residents whose files were reviewed had been using restraint for less than six months. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality meetings. Evaluation timeframes are determined by policy and risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed six-monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly quality meetings. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Quality data has been collected and the number of incidents and infections by type has been reported to staff at quality/health and safety meetings. The service has recently been linked to the CHT data collection system which will provide graphs and benchmarking. | There was not documented evidence that quality data has been analysed for trends. | Ensure that quality data is analysed for trends and that these are communicated to staff.  90 days |
| Criterion 1.2.4.2  The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. | PA Low | The unit manager and area manager are familiar with situations requiring essential notification. Oversight meant that a police investigation was not notified, | An incident involving a police investigation was not notified to HealthCERT. | Ensure that all incidents are notified to HealthCERT where this is required.  90 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | Policy includes that whenever a resident has a potential or actual knock to the head, neuro observations are to be completed. Three incident forms sampled where the resident had experienced a potential or actual knock to the head documented on the incident form that these had been completed but no observation records were available to support this. | Three incidents where neuro observations were required did not have completed neuro observation forms available to confirm these had occurred. | Ensure neuro observations are completed and documented when a resident has a potential head injury.  60 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | CHT has documented requirements to be included in the staff education programme that includes all required training. Carnarvon has a documented 2016/2017 training plan that does not include all required trainings and several sessions of required training that had been planned had been cancelled. Staff, including registered nurses and healthcare assistants, have attended external training provided by the DHB or hospice, either as small groups or as individuals, depending on spaces available and staff numbers that could be released. Staff training (in required areas) has been provided for the full staff around fire safety, medication management, infection control and health and safety. | Education provided has not covered most required topics or providing support to all residents included younger people. | Ensure all staff receive training in all required areas including providing support to meet the needs of all residents.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | All medications are stored safely. There are regular checks in place for imprest stock, ‘as required’ medications, medication fridge temperatures, emergency trolley, oxygen and suction checks. Not all imprest stock medications were within the expiry date. | There were six imprest stock medications that had expired. | Ensure all medications in stock are checked for expiry dates.  60 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | Relevant risk assessments are completed on admission in four of the six files reviewed. The outcomes of the risk assessments (including interRAI assessments) are reflected in the care plans. | Risk assessments had not been completed on admission for two residents; 1) one respite care resident with a history of falls did not have a falls risk assessment and there were no falls prevention strategies documented and 2) there was no pain and pressure injury risk assessment completed for one resident admitted for palliative care. | Ensure applicable risk assessments are completed on admission.  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | Five long-term care plans and one short-term (respite) care plan were reviewed. One other resident file was reviewed for restraint documentation. The care plans for three long-term residents described the current supports to meet the resident’s needs. | a) The care plans for two long-term residents (one ARCC and one ACC resident) had not been updated to include interventions for weight loss. b) The short-term care plan for the respite resident had not been updated to include falls prevention strategies or the use and risks of using an enabler (cot sides). c) One long-term resident with a restraint did not have the associated risks of using a restraint documented in the care plan. | a) Ensure interventions are documented for residents with weight loss. b) Ensure the respite care plans are reviewed with each episode of respite care. c) Ensure risks are identified and documented for restraint and enabler use.  60 days |
| Criterion 2.2.2.1  In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to: (a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; (c) Existing advance directives the consumer may have made; (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the consumer being held against their will; (f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies. | PA Low | In the two files sampled discussion with the unit manager (the restraint coordinator) demonstrated that restraint assessments were being completed but not documented. The change of documentation to the CHT documentation meant the restraint coordinator had not been aware of the restraint assessment form. Rectification of this issue was commenced during the audit. | The two resident files sampled that use restraint did not have documented comprehensive assessments. | Ensure assessments that meet the requirements of criterion 2.2.2.1 (a) to (h) are completed and documented.  60 days |

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

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

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

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

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End of the report.