

CHT Healthcare Trust - CHT Bernadette

Introduction

This report records the results of a Surveillance 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:	CHT Bernadette
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 October 2017 End date: 10 October 2017
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:	81

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

CHT Bernadette is owned and operated by the CHT Healthcare Trust and provides care for up to 113 residents requiring hospital and rest home level care. On the day of the audit, 26 beds were closed and there were 81 residents. The service is overseen by a unit manager, who is well qualified and experienced for the role and is supported by a clinical coordinator and the area manager.

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

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

The one shortfall, specifically around documenting indications for use for 'as required' medications, identified at the previous audit, has been addressed. However, in general shortfalls around medication management continue to require addressing.

This audit has identified areas requiring improvement around meeting minutes, corrective action plan sign off, care planning, wound documentation, monitoring charts, medication self-administration competency assessments, emergency restraint use and consents for enabler use.

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.
--	--	--

Policies are in place to support residents' rights, communication and complaints management. There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

Organisational management

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

CHT Healthcare Trust has an overall business/strategic plan and CHT Bernadette has a facility documented quality and risk management programme. There are monthly quality/health and safety/staff meetings. Residents and relatives are provided with the opportunity to feedback on service delivery issues at three-monthly resident meetings and via satisfaction surveys. There is a reporting process being used to record and manage resident accident/incidents. Accident/incidents are collated monthly and reported to facility meetings. Health and safety policies, systems and processes are in place to manage risk. CHT Bernadette has job descriptions for all positions that include the role and responsibilities of the position. There is an annual in-service education calendar schedule in place for 2017. The service has a documented rationale for determining staff rationale and skill mix. Residents and family members report staffing levels are sufficient to meet resident needs.

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>
---	--	---

A registered nurse completes initial assessments, including interRAI assessments. The registered nurses complete care plans and evaluations within the required timeframe. Residents interviewed confirmed they were involved in the care planning and review process. The general practitioner reviews the residents at least three-monthly or more frequently if needed.

Each resident has access to an individual and group activities programme. The group programme is varied and interesting.

Medicines are stored and managed appropriately in line with legislation and guidelines. Staff responsible for the administration of medication complete annual competencies and medication education. General practitioners review resident's medications at least three monthly.

Meals are prepared on-site by a contracted agency under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

Safe and appropriate environment

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

A current building warrant of fitness is posted in a visible location.

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.
---	--	---

CHT Bernadette has restraint minimisation and safe practice policies and procedures in place. At the time of the audit there was one hospital level resident with two restraints and two hospital level residents using three enablers. Staff receive training in restraint minimisation and management of challenging behaviour.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
--	--	---

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	12	0	2	2	0	0
Criteria	0	33	0	4	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. The complaints procedure is provided to residents and their family within the information pack at entry. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at reception. Complaints received are discussed in the monthly quality/health and safety/staff meetings. There is a complaint's register in place. Twenty-two complaints were made in 2016 and twenty-one complaints received in 2017 year-to-date. Complaints reviewed for 2017 evidenced that the appropriate actions have been taken and the complainant received documented outcome of the complaint. One complaint made through the Health and Disability Commissioner (HDC) in 2016 is ongoing and is currently being investigated by the CHT Healthcare Trust.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Eight residents interviewed (three hospital and five rest home) 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. Ten accident/incident forms were reviewed for September 2017. The accident/incident form includes a section to record family notification. All accident/incident forms reviewed indicate family are informed. Two families interviewed (one hospital and one rest home) confirmed</p>

<p>provide an environment conducive to effective communication.</p>		<p>they are notified of any changes in their family member's health status. The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>CHT Bernadette is owned and operated by the CHT Healthcare Trust. The service provides hospital and rest home level care for up to 113 residents. At the time of the audit 26 beds were closed and there was a total of 87 beds available. There were 81 residents in total, 33 rest home level residents including one resident on a long-term support chronic health condition (LTS - CHC) contract. There were 48 hospital level residents including one resident on respite, one resident on a younger person's with disability (YPD) contract, two residents on LTS - CHC contracts and one on ACC funded contract.</p> <p>The unit manager is a registered nurse (RN) and maintains an annual practicing certificate. She has been with CHT Healthcare Trust since 2010 and has been in the unit manager role at Bernadette since August 2015 (she has previously managed another CHT facility). She is supported by a clinical coordinator and an area manager. The clinical coordinator has been in the role since November 2015 and has been with CHT Healthcare Trust for seven years. The unit manager reports to the area manager weekly, on a variety of operational issues.</p> <p>CHT Healthcare Trust has an overall business/strategic plan and CHT Bernadette has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement.</p> <p>The unit manager has completed in excess of eight hours of professional development in the past 12 months.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The quality and risk management programme is designed to monitor contractual and standards compliance. Quality data related to incident and accidents, infection control, hazard management, environmental safety, restraint minimisation, complaints and training and audit outcomes are collected. The quality/health and safety/staff meeting template includes headings relating to these items, however there was no documented evidence that included discussion around quality data trends analysis and what actions were required by staff. The unit manager advised that she is responsible for providing oversight of the quality programme. Residents and relatives are provided with the opportunity to feedback on service delivery issues at three monthly resident meetings and via satisfaction surveys. Resident and relative surveys are completed with results communicated to residents and staff.</p> <p>The service's policies are reviewed at national level with input from facility staff every two years. New/updated policies are sent from head office. Staff have access to manuals. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement, however, not all corrective actions resulting from internal audits had been completed and signed off. The service has a health and safety management system. There are risk management,</p>

		and health and safety policies and procedures in place including accident and hazard management. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an accidents and incidents reporting policy. The unit manager and clinical coordinator investigate accidents and near misses and analysis of incident trends occurs. There is a discussion of accident/incidents at monthly quality/health and safety/staff meetings including actions to minimise recurrence. Twelve accident/incident forms reviewed documented that clinical follow-up of residents is conducted by a RN. Discussions with the unit manager and area manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been three pressure injuries reported since the last audit, one stage three pressure injury in June 2017, one stage four pressure injury in September 2017 and one unstageable pressure injury in October 2017. A gastro outbreak in January 2017 was also reported to the Public Health authorities.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place, including the requirement that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files reviewed, one clinical coordinator, one RN, one activities coordinator and two healthcare assistants (HCAs) evidences that reference checks are completed before employment is offered. Annual staff appraisals and orientation checklists were evident in all five of the staff files reviewed.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2016 has been completed and the 2017 programme is being implemented. Healthcare assistants have completed an aged care education programme. The unit manager and RNs can attend external training including sessions provided by the local DHB. Five of ten RNs are interRAI trained with one RN currently in progress.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	FA	<p>CHT Healthcare Trust policy includes staff rationale and skill mix. Staff are rostered on to manage the care requirements of the residents. Interviews with staff (four healthcare assistants, two registered nurses, two activities coordinators, the kitchen manager, the clinical coordinator and the maintenance person), residents and family</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>members identified that staffing is adequate to meet the needs of residents.</p> <p>The facility consists of four units across two floors (one 25 bed hospital unit, one 25 bed rest home/hospital (Matakana Down) unit and one 12 bed rest home (Pink) unit all on the ground floor and one 25 bed hospital/rest home (Matakana Up) unit on the first floor.</p> <p>The unit manager and clinical coordinator work full time from Monday to Friday, two RNs are rostered on the morning shift and two RNs on the afternoon shift (one in the hospital unit and one in the Matakana Down) and one RN in the hospital unit on the night shift. The RNs hold current first aid/CPR certification. Adequate numbers of HCAs are rostered.</p> <p>In the 25-bed hospital unit, (14 rest home and 11 hospital residents); there are three HCAs rostered on the morning shift, three HCAs on the afternoon shift and one HCA on the night shift.</p> <p>In the 25 bed Matakana Down unit, (17 rest home and 8 hospital residents); there are two HCAs rostered on the morning shift, two HCAs on the afternoon shift and one HCA on the night shift.</p> <p>In the 12 bed Pink unit, (8 rest home residents); there is one HCA rostered on the morning shift and one HCA on the afternoon shift.</p> <p>In the 25 bed Matakana Up unit, (6 rest home and 14 hospital), there are three HCAs rostered on the morning shift, three HCAs on the afternoon shift and one HCA on the night shift.</p> <p>There is also an additional HCA on the morning shift floating between the Matakana Up and Down units. Extra staff are called on for increased resident requirements.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The RN on duty checks medications against the electronic medication chart. Registered nurses administer medications and have completed competencies including syringe driver competency. Senior HCAs have completed medication competencies. Medication administration practice complies with the medication management policy for the medication administration sighted. Medication prescribed is not always signed as administered in the electronic record and the efficacy of 'as required' medications is not always documented. There is one resident who self-administers their own insulin, but no competency assessment was completed. Standing orders are not in use.</p> <p>Eighteen medication charts were reviewed. Not all medication charts had been reviewed at least three monthly. Medication charts met the legislative requirements for the prescribing of regular medications. All prescriptions for 'as required' medications document the indication for use. This is an improvement since the previous audit. Staff described administering common medications that were not prescribed.</p> <p>Medication is stored in a locked area in each of the four wings. Medication fridges were not all maintained at the correct temperature and eyedrops were not always dated when opened and eye drops, and other expired medications were not always returned to the pharmacy.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<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. The kitchen is able to meet the needs of residents who require special diets and the chef manager works closely with the RNs on duty. The kitchen staff have completed food safety and chemical safety training. The kitchen manager and cooks follow a rotating four weekly seasonal menu, which has been reviewed by the contracted company's dietitian. The cook (interviewed) was able to describe alternative meals offered for residents with dislikes and the Replenish Energy and Protein (REAP) programme for weight loss. Temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were happy with the quality and variety of food served.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Registered nurses (RNs) (including the clinical coordinator) and HCAs, follow the care plan and report progress against the care plan each shift at handover. However, not all identified needs (short and long-term) were addressed in care plans. If external nursing or allied health advice is required, the RNs will initiate a referral as evidenced in resident files. If external medical/specialist advice is required, this is initiated by the GP. The DHB clinical nurse specialist visits the facility and provides support most weeks. A physiotherapist is on-site eight hours per week and the GP visits twice weekly.</p> <p>Staff have access to sufficient dressing supplies. Sufficient continence products are available and resident files include a continence assessment and plan in the care plan. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, monitoring, wound management plans and short-term care plans are in place for all minor wounds and chronic wounds (documentation for 18 wounds sampled) and one stage four (non-facility acquired), one grade three (present on admission) and two grade two (facility acquired) pressure injuries. Not all residents with wounds had separate documentation for each wound. The RNs have access to specialist nursing wound care management advice through the district health board and regular evidence of this was sighted in resident files and wound documentation sampled.</p> <p>Appropriate documentation was in place for residents on long-term restraint but not for a resident requiring emergency restraint.</p> <p>Food and fluid records, weight monitoring, BSL monitoring and vital signs monitoring records were regularly completed. Turning charts and pain monitoring were not.</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>FA</p>	<p>A team of three activity coordinators are employed to deliver the activities programme seven days a week, with two activities coordinators rostered every day except Sunday. The activities provided meet the recreational preferences and abilities of the resident groups and include art and crafts, exercises, walks and board games. Activities reflect ordinary patterns of life and include planned visits to the community. Activities are held in the rest home and hospital lounges, with some activities integrated such as happy hour, entertainment and bowls. One-on-one time is spent with residents who choose not to or are unable to participate in group activities.</p> <p>Each resident has an individual activities assessment on admission, which is incorporated into the interRAI assessment process. An individual activities plan is developed for each resident in consultation with the resident/family. Plans for younger residents are also individualised and include activities that interest the person and are age appropriate, such as shopping, social media, preferred music and television programmes and going out for coffees or meals. All long-term resident files sampled had a recent activity plan within the care plan and this is reviewed at least six monthly when the care plan is evaluated or a further interRAI assessment occurs. Residents interviewed commented positively on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The registered nurses evaluate all initial care plans within three weeks of admission. In files sampled the long-term care plan was evaluated at least six monthly or earlier if there was a change in health status. There is at least a three-monthly review by the GP. Not all changes in health status is documented and followed up (link 1.3.6.1). Files sampled demonstrated six monthly reassessments have been completed by RNs using interRAI LTCF for all residents that had been at the service longer than six months, and for those who have had a significant change in health status. Short-term care plans (link 1.3.6.1) are evaluated and resolved or added to the long-term care plan if the problem is ongoing (link 1.3.6.1), as sighted in resident files sampled. Where progress is different from expected, the service does not always respond by initiating changes to the care plan (link 1.3.6.1).</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 their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location, expiry 22 April 2018.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance includes the reporting of all infection occurrences by the registered nurses and infection control coordinator. It is described in CHT's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used (link 1.3.6.1). Surveillance of all infections is entered onto a monthly infection summary. Outcomes and actions are discussed at the quality/health and safety meeting (link 1.2.3.6). 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, although a suspected outbreak in September 2017 was treated as an outbreak until it was determined this was not the case.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Low</p>	<p>The service has documented systems in place to ensure that the use of restraint is actively minimised. An RN is the designated restraint coordinator. At the time of the audit there was one hospital level resident with two restraints (one bed rail and one lap belt) and two hospital level residents using three enablers (two bed rails and one lap belt). Restraint processes are in place to assess residents for enabler use, but consent for enablers is not always documented. Staff interviews, and staff training records evidenced guidance has been given on restraint minimisation and management of challenging behaviour. Restraint/enablers are discussed in the monthly quality/health and safety/staff meetings.</p>

Specific results for criterion where corrective actions are required

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

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

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

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	The quality and risk management programme is designed to monitor contractual and standards compliance. Quality data related to incident and accidents, infection control, hazard management, environmental safety, restraint minimisation, complaints and training and audit outcomes are collected. The quality/health and safety/staff meeting template includes headings relating to these items, however, there was no documented evidence that included discussion around quality data trends analysis.	There was no documented evidence that quality/health and safety/staff meetings included discussion around quality data trends analysis and what actions were required by staff.	Ensure that staff meeting minutes include discussion of quality data trends analysis and actions required, if any. 90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in	PA Low	Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement, however, not all corrective actions	Thirty-four areas of non-compliance were identified for improvement through the 2017 internal audit monitoring process. Corrective action plans were developed for the thirty-	Ensure that all corrective action plans resulting from internal audits had been completed and signed

<p>order to meet the specified Standard or requirements is developed and implemented.</p>		<p>resulting from internal audits had been completed and signed off.</p>	<p>four areas not compliant. Eleven out of the thirty-four corrective actions did not have documented evidence of being followed-up and/or signed off as completed.</p>	<p>off. 90 days</p>
<p>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.</p>	<p>PA Moderate</p>	<p>The service has appropriate policies and procedures around medication storage and administration, but these are not always implemented. Medication was administered and recorded correctly on the medication round observed. However, staff described administering medication that was not prescribed, not all prescribed medication was documented as administered and when 'as required' medications were administered their effectiveness was not always documented.</p> <p>The GPs prescribe all medications electronically but not all medication charts had been reviewed three monthly. Medication is stored securely in each of the three wings and in three of the four wings, the medication fridges were within the safe range. Eye drops were discarded when expired in three of the four wings and dated when opened in three of the four wings. Three of the medication storage areas did not have expired medications.</p>	<p>(i) There were expired medications in the upstairs Matakana medication cupboard.</p> <p>(ii) There were three bottles of expired eye drops in use in the hospital.</p> <p>(iii) One open bottle of eye drops in the rest home had not been dated when opened.</p> <p>(iv) Weekly medication fridge temperatures in the hospital have been 0 degrees or below since 27 August 2017 with no corrective action taken.</p> <p>(v) One registered nurse interviewed described administering medications such as paracetamol or loperamide that were not prescribed and following administration, ringing the doctor for a verbal order.</p> <p>(vi) Three of ten electronic medication charts sampled had prescribed medications that had not been administered with no comment documented as to the reason.</p> <p>(vii) Four of ten electronic medication charts sampled had not been</p>	<p>(i)and (ii) Ensure expired medications are appropriately disposed of.</p> <p>(iii) Ensure all eye drops are dated when they are opened.</p> <p>(iv) Ensure medication fridges are maintained at a safe temperature.</p> <p>(v) Ensure only medications that are prescribed are administered.</p> <p>(vi) Ensure a GP reviews all medications at least every three months.</p> <p>(vii) Ensure the efficacy of 'as required' medication is documented</p> <p>30 days</p>

			<p>reviewed three monthly by the GP.</p> <p>(viii) None of the five medication charts sampled where 'as required' medication had been administered had the efficacy documented.</p>	
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	<p>The service has a policy that includes any resident that self-administers medications must have a competency assessment. At the time of the audit one resident was self-administering insulin. The insulin is stored in the medication fridge and staff take it to the resident for them to administer. The resident was interviewed and had a comprehensive knowledge of how to administer the insulin, but a competency assessment was not documented.</p>	<p>The one resident that self-administers medication (insulin) does not have a documented competency assessment around self-medication.</p>	<p>Ensure all residents that self-administer medications have a competency assessment completed.</p> <p>60 days</p>
<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>	PA Moderate	<p>Healthcare assistants and registered nurses interviewed were able to describe the individual needs of each resident in the file sample despite not all needs (both acute and long-term) being documented in care plans or monitoring records. All staff and the restraint coordinator interviewed, were aware of restraint management and minimisation techniques and documentation required according to the scope of their role. During interviews it was explained that one restraint used in an emergency did not have documentation other than in progress notes, as staff had not realised it was required. All staff were aware of the risks of restraint to residents and the cares/monitoring required to manage these.</p> <p>Wound documentation, care plans, progress notes</p>	<p>(i) A hospital level resident had an emergency restraint implemented. It was in place for one week but no assessment or care plan (short-term) was documented.</p> <p>(ii) Three residents, each with two wounds, had both wounds in the same assessment, plan and evaluations.</p> <p>(iii) Four of the five resident files sampled (one rest home and three hospital) did not have interventions documented in the care plan to address all identified needs. Examples include: depression, behaviour, use of a special pressure relieving shoe, challenging behaviour, postural hypotension, use of a Steady</p>	<p>(i) Ensure that an appropriate assessment and plan of care to reduce the risks is completed for any resident using restraint.</p> <p>(ii) Ensure each wound has an individual assessment, management plan and evaluation.</p> <p>(iv) Ensure that care plans include interventions for all identified needs.</p> <p>(iv) Ensure that cares</p>

		and interviews evidenced regular input from the wound nurse specialist and comprehensive individual assessments, management plans and evaluations for chronic wounds and pressure injuries. Not all minor wounds had individual documentation completed.	Eddy, continence, specific bowel cares requested by the spinal unit, lap belt, warfarin use, compression stockings, need to push fluids (from wound nurse specialist, MRSA, diabetes on insulin, poor vision and seizures. (iv) One resident (rest home) had a plaster cast on an arm. There was no short-term care plan or update to the long-term care plan around this. (v) Two of two turning charts and one of two pain monitoring charts sampled did not have regular monitoring/turning documented.	for short-term needs are documented in a care plan. (v) Ensure monitoring/interventions that are required occur and are documented. 30 days
Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.	PA Low	The service has documented systems in place to ensure that the use of restraint is actively minimised. Restraint processes are in place to assess residents for enabler use, which is voluntary. However, there was no documented assessments or consents completed for one resident's bed rail and lap belt enablers. The resident was interviewed and confirmed that the enablers are voluntary. The enabler was also not in the resident's care plan (link 1.3.6.1)	There is one resident with two enablers (one bed rail and one lap belt). For the bed rail enabler there was no documented assessment or consent completed. For the lap belt enabler that had been in place for six months, there was no documented assessment or consent completed until one month before the audit.	Ensure that there are documented assessments and consents completed for all enablers. 90 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.