

CHT Healthcare Trust - Highfield Home and Hospital

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	CHT Healthcare Trust	
Premises audited:	Highfield Home and Hospital	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care	
Dates of audit:	Start date: 22 January 2018	End date: 23 January 2018
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:	46	

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
	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

Highfield Home and Hospital is part of the CHT group of facilities. The facility is purpose-built providing three levels of care (hospital – geriatric/medical, rest home and dementia) for up to 60 residents. On the day of audit there were 46 residents. The residents and relatives spoke positively about the care provided.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with family, management, staff and the general practitioner.

The service has been establishing CHT systems and processes since opening in April 2017.

This audit identified improvement required around and care plan documentation and monitoring.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on noticeboards. Policies are implemented to support rights such as: privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Family state they are kept well informed on their relative's health status. Residents are encouraged to maintain links with the community. Complaints processes are implemented, and complaints and concerns are managed appropriately.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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There is a business plan with goals for the service that has been regularly reviewed. Highfield Home and Hospital has a fully implemented, robust quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has a training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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There is a comprehensive admission package available prior to, or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and caregivers responsible for the administration of medicines complete education and medication competencies. Medication charts are reviewed three monthly by the general practitioner.

The activities coordinator and staff 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. Residents and families report satisfaction with the activities programme.

All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. A selection of residents' rooms have ensuites and there are sufficient communal showers/toilets for the others. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are constructed for ease of resident access and ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system and surveys. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. There is a trained first aider on duty 24 hours.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are policies and procedures on safe restraint use and enablers. A registered nurse/quality and risk coordinator is the restraint coordinator. On the day of the audit, there were three with restraints in use (lap belts) and one resident with a lap belt as an enabler. Staff receive training around restraint and challenging behaviours.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (RN) is responsible for coordinating education and training for staff. The infection control coordinator has completed annual external training. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	48	0	2	0	0	0
Criteria	0	99	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>There are policies and procedures in place around resident rights. Nine residents (five rest home and four hospital level of care) and five relatives (three hospital level, one rest home and one dementia level of care) interviewed, confirmed that information has been provided around the code of rights. Residents state that their rights are respected when receiving services and care. Discussion with six caregivers and three registered nurses (RN) identified that they are aware of The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) and could describe the key principles of resident's rights when delivering care.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>The service has in place a policy for informed consent and advance directives. Completed advance directive forms were evident on all resident files reviewed (three hospital, two rest home and two dementia). General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney evidence is filed in the residents' charts.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Resident advocates are identified during the admission process. Pamphlets on advocacy services are available at the entrance.</p> <p>Interviews with the residents and relatives confirms their understanding of the availability of advocacy services. Staff receive education and training on the role of advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has an open visiting policy and family/whānau and friends are encouraged to visit the home and are not restricted to visiting times. All residents interviewed confirm that family and friends are able to visit at any time and visitors were observed attending the home. Residents and relatives verified that they have been supported and encouraged to remain involved in the community.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy/procedure in place and the complaints process is provided to residents and relatives on entry to the service, complaints forms are available to residents and relatives. A record of all complaints is maintained on the on-line complaint register. The facility manager manages complaints.</p> <p>There have been two internal complaints since the service opened eight months ago. The complaints/concerns have been managed in line with Right 10 of the Code. A review of complaints documentation evidence resolution of the complaints to the satisfaction of the complainants. Changes to resident's care plans have been made following complaints and meetings with family. Residents and family members advise that they are aware of the complaints procedure. Discussion around concerns, complaints and compliments are evident in facility meeting minutes.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The service has information available on The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) at the main entrance to the facility. The Code (English and Māori) is also displayed in the resident areas. There is a welcome information folder that includes information about the Code. The resident, family or legal representative has the opportunity to discuss this prior to entry and/or at admission with the clinical manager. Residents and relatives state they receive sufficient verbal and written information to be able to make informed choices on matters that affect them. There is specific information</p>

		around dementia care provided to relatives and visitors.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff are able to describe how they maintain resident privacy, including knocking on the resident's doors before entering as observed on the day of audit. Education around privacy and dignity, prevention of abuse and neglect in-service is provided as part of the education plan. Resident's cultural, social, religious and spiritual beliefs are identified on admission and included in the resident's care plan/activity plan.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	There are cultural awareness policies and a Māori health plan to guide staff in the delivery of culturally safe care. The Kaumātua provides blessing for the site and prayers as needed. There were no residents who identify as Māori on the day of audit.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Care plans are reviewed at least six monthly to ensure the resident's individual culture, values and beliefs are being met. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with regular church services in the on-site chapel. Weekly church services held on-site and there are designated staff who provide pastoral care.

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The staff employment process meets best practice with regard to recruitment, including reference checks and police vetting. Professional boundaries are defined in job descriptions. Staff were observed to be professional within the culture of a family environment. Caregivers interviewed were able to describe how they recognise and report any suspected abuse and the service's zero tolerance policy. Residents interviewed stated that they are treated fairly and with respect.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has implemented policies and procedures that provide a good level of assurance that it is adhering to relevant standards. Care staff and registered nurses (RNs) have access to internal and external education opportunities. Regular facility and clinical meetings and shift handovers enhance communication between the teams and provide consistency of care. The service is implementing quality teams around wound care, falls prevention, a nutrition programme (REAP), infection control, continence and restraint prevention. These have been effective at maintaining high standards at other CHT facilities for the manager. The service employs a physiotherapist for six hours per week over two days, who completes resident mobility assessments and provides safe manual handling training for staff. All residents and families speak positively about the care provided.</p> <p>New initiatives include; the implementation of a medication software package in close liaison with the pharmacy, commencing a resident focus group made up of residents, a family member and the facility manager (the group is focusing of meals as its first project) and also a staff focus group has had its first meeting. The service has also developed links with the palliative care services.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Management promote an open-door policy. Relatives/residents are aware of the open-door policy and confirm on interview that the staff and management are approachable and available. Residents/relatives have the opportunity to feedback on service delivery through resident meetings and annual surveys. The resident meetings are bi-monthly and there is also a resident's focus group, currently looking at meals. Residents and relatives receive newsletters.</p> <p>Accident/incident forms reviewed document that relatives have been notified of the incident. Relatives interviewed state they are notified promptly of any changes to resident's health status.</p> <p>Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. An interpreter service is available if required.</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>	FA	<p>Highfield Home and Hospital is part of the CHT group of facilities. The facility opened on the 8 April 2017. The building is a purpose-built facility providing three levels of care (hospital – geriatric/medical, rest home and dementia) for up to 60 residents. On the day of audit there were 46 residents. There were 21 hospital and 13 rest home level residents in the 40-bed dual-purpose unit and 12 in the 20-bed secure dementia unit. All residents were under the age-related residential care services agreement.</p> <p>A CHT strategic plan 2016 – 2019 has been developed and includes business plan targets for 2017. Highfield Home and Hospital has set a number of quality goals and these also link to the organisation’s strategic goals.</p> <p>A facility manager is in place to manage the smooth transition and opening of the service. The manager (RN) has previous management experience within CHT, she transferred into the role previous to opening. She is supported by a clinical coordinator (an experienced RN) and an area manager. The manager and clinical coordinator have completed at least eight hours of professional development.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During the temporary absence of the facility manager the clinical coordinator will provide management oversight of the facility with the support of the area manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>CHT has a well-established and comprehensive quality and risk programme and this has been established at Highfield Home and Hospital since opening.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff (six caregivers, three registered nurses, one cook, one house keeper and the clinical coordinator) confirmed they were made aware of policies during their induction to this new service.</p> <p>Since opening, the service has established monthly quality meetings. These document staff discussions around accident/incident data, health and safety, infection control, and concerns. Quality focus groups have also been established around: falls prevention, continence, wound care, nutrition (REAP), restraint and infection control. Each of these groups presents a report at the monthly quality meeting. The service collates</p>

		<p>accident/incident and infection control data. Monthly comparisons include trend analysis and graphs.</p> <p>Additional meetings include: two monthly resident/family meetings for which a focus group has been commenced to review meals and mealtimes. The service has commenced an employee focus group (first meeting held), this group has an aim of employee wellbeing. A registered nurse meeting convenes monthly, and commenced in November 2017.</p> <p>There is a robust internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. A six-monthly comprehensive internal audit against the Health and Disability Standards has been completed by the area manager. Other audits including: infection control, restraint and medication are also completed as per the internal audit schedule. Areas of non-compliance identified are actioned for improvement.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The manager is responsible for health and safety. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings.</p> <p>Falls management strategies include assessments after falls and individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around this.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service collects incident and accident data on forms, which are collated monthly and are discussed at the staff meetings, quality and health and safety meetings.</p> <p>Ten incident forms were reviewed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury (link to 1.3.6.1 for neuro obs). The next of kin had been notified for all required incidents/accidents. The healthcare assistants interviewed could discuss the incident reporting process. The clinical coordinator collects incident forms, investigates and reviews, and implements corrective actions as required.</p> <p>The facility manager interviewed could describe situations that would require reporting to relevant authorities. There have been no reports to the Ministry of Health.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes</p>	FA	<p>There are human resources policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Seven staff files were reviewed (two RNs and five HCAs). All files contained relevant employment documentation including orientations. Senior (experienced) HCAs described a mentoring programme for the new, less experienced HCAs. The education planner</p>

<p>are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>documents a two-week induction programme for all staff, with additional training session over the year. Training records document that all compulsory training has been provided, with good staff attendance. Current practising certificates were sighted for the registered nurses. Registered nurses and caregivers have access to external training, which includes clinical education relevant to medical conditions such as the palliative care course. Five RNs are interRAI competent. Staff complete competencies relevant to their roles.</p> <p>Of the nine caregivers working in the dementia unit, eight are enrolled for required dementia units and one has completed. The clinical coordinator has experience in mental health nursing and provides additional leadership in the unit. All RNs have a current first aid certificate.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Policy is in place to determine staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The manager and assistant clinical coordinator are on duty during the day Monday to Friday. Both share the on-call requirement for clinical concerns.</p> <p>The RN cover is provided for an RN for each shift, seven days a week, plus an additional RN from midday to 8.00 pm.</p> <p>Healthcare assistants are staffed according to units;</p> <p>Koru (two wings; 14 residents in total on the day of audit- five hospital and nine rest home) two HCA for the am and for the PM and one at night.</p> <p>Mana (two wings; 20 residents in total on the day of audit - four rest home residents and 16 hospital) two long shifts and one short shift for the AM and the PM shifts and one at night.</p> <p>Dementia (two wings; 12 residents) the clinical coordinator assists in the am and undertakes the medication rounds. For the am and the pm each has one long-shift and one short-shift HCA and one HCA for the night shift.</p> <p>Residents and relatives state there are adequate staff on duty at all times. Staff state they feel supported by the management team who respond quickly to after hour calls.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable,</p>	<p>FA</p>	<p>There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents' individual record and resident register. Resident clinical and allied health records are integrated. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation.</p>

accurately recorded, current, confidential, and accessible when required.		
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy.</p> <p>The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the Age Related Residential Contract (ARCC). Exclusions from the service are included in the admission agreement. All five admission agreements viewed were signed and dated.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and 'the yellow envelope' is used. The RNs report that they include copies of all the required information in the envelope.</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>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit.</p> <p>The facility uses a four-week robotic sachets system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses administer medications in the hospital, rest home and dementia care unit. Medication competencies are updated annually, and staff attend annual education. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature is checked daily. Eye drops are dated once opened.</p> <p>Registered nurses use an electronic medication management system and sign for the administration of medications. Fourteen medication charts were reviewed. Medications have been reviewed at least three monthly by the GP. Photo ID and allergy status are recorded. 'As required' medications have indications for use charted.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service employs a contract company to provide all meals. There are two cooks who, between them, cover all shifts. There is also a kitchenhand during the day. All have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on-site. Meals are served directly from a mobile hot box in all dining rooms. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. The four-weekly seasonal menu cycle is written and approved by an external dietitian. All resident/families interviewed are happy with the meals. Additional snacks are available at all times in the dementia unit.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicate that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files contain appropriate assessment tools and assessments that have been reviewed at least six monthly or when there was a change to a resident's health condition. The interRAI assessment tool is implemented. InterRAI assessments have been completed for all long-term residents. Care plans sampled have been developed on the basis of these assessments.</p>
<p>Standard 1.3.5: Planning Consumers' service</p>	PA Low	<p>The seven resident files reviewed identified that care plans include generic instructions and were not always resident-focused. Care plans reviewed evidence multidisciplinary involvement in the care of the resident.</p>

<p>delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>Short-term care plans (STCPs) are in use for changes in health status and are STCP's reviewed had been evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan if an ongoing problem. There is evidence of service integration with documented input from a range of specialist care professionals including: the podiatrist, physiotherapist, dietitian and mental health care team for older people. The care staff advise that the care plans are easy to follow.</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 Low</p>	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff state that they notify family members about any changes in their relative's health status. All five long-term care plans sampled, have interventions documented. Care plans have been updated as residents' needs changed.</p> <p>Resident falls are reported on accident forms and written in the progress notes.</p> <p>Care staff state there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned. There are two wounds in the rest home (two skin tears), four wounds in the hospital (one lesion, two skin tears and one pressure injury) and no wounds in the dementia unit. There was one non-facility acquired pressure injury - grade 3. The facility has accessed the wound care specialist advice as required. A section 31 had been completed and submitted.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs and wounds, however, one resident care plan which instructed staff to monitor swollen legs twice daily had no monitoring form in place to record the monitoring. Neurological observations were not monitored according to set timeframes. Behaviour charts are available for any residents that exhibit challenging behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is one activity coordinator who covers five days a week who leads all activities, with caregivers providing some of the activities. The dementia unit has a dedicated activities programme which is facilitated by the activity coordinator and caregivers. On the days of audit residents were observed participating in exercises, watching a movie, colouring in and knitting.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities in which to participate. These include (but not limited to) exercises, walks outside, crafts, games and quizzes.</p> <p>Those residents who prefer to stay in their room have one-on-one visits to check if there is anything they need and to have a chat.</p>

		<p>There are weekly church services and the denominations rotate.</p> <p>There are van outings twice a week. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day and Anzac Day are celebrated. There was evidence of Easter craft sessions.</p> <p>There are visiting community groups such as choirs and children's groups.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career and family. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term nursing care plan has been evaluated at least six-monthly or earlier if there was a change in health status. There was at least a three-monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the dietitian and mental health services for older people. Discussion with the registered nurse confirms that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a</p>	FA	<p>There are policies regarding chemical safety and waste disposal. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals are clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharps containers are available in the sluice rooms and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicate a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. The maintenance person described the safe management of hazardous material.</p>

result of exposure to waste, infectious or hazardous substances, generated during service delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a Certificate of Public Use (dated 16 May 2017). There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged. All hoists and scales have been checked and tagged. Hot water temperatures have been monitored randomly in resident areas and are within the acceptable range. The communal lounges and hallways are carpeted. The utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Residents' rooms are carpeted and ensuites and communal showers and toilets have nonslip vinyl flooring. All halls have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas, courtyards and gardens are well maintained. All courtyards have attractive features and are easily accessible to residents. The dementia unit has a walking pathway, gardens and raised garden beds. All outdoor areas have some seating and shade. There is safe access to all communal areas.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All rooms have single occupancy. There were a variety of rooms throughout the facility with ensuite toilets and sink. All residents shower using one of the two large communal bathrooms in each dual-purpose wing. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are well maintained and easy to clean. There is ample space in all toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are privacy signs on all shower/toilet doors. There are visitor toilets available in the main corridor.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided</p>	FA	<p>Residents' rooms are spacious and allow care to be provided and the safe use of mobility aids. Staff report that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>

<p>with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are communal areas at the end of each wing. Activities occur in the communal areas, with residents assisted from other wings to attend. There are spaces where residents, who prefer quieter activities or visitors, may sit. Some lounges open out onto attractive courtyard areas. The communal lounges are also used as dining rooms.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is contracted out. There is a washer and dryer available for caregivers to complete some personal clothing laundry. There is a comprehensive laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times, or locked away in the cleaners' room as sighted on the day of the audit. Cleaning is done by on-site cleaners. There are three sluice rooms for the disposal of soiled water or waste. The sluice room and the laundry are kept closed when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. There is a staff member with a first aid certificate on duty at all times. The facility has a fire evacuation plan that has been approved by the fire service 5 April 2017. A fire drill was completed as part of induction and 20/10/2017. Smoke alarms, sprinkler system and exit signs are in place. A gas barbeque and torches are available in the event of a power failure. Emergency lighting is in place. A civil defence kit is in place. Supplies of stored water is in tanks. Electronic call-bells are evident in resident's rooms, lounge areas and toilets/bathrooms. All call bells have an emergency button available and all bells alert on electronic panels visible throughout each suite. There is a keypad lock into the dementia unit.</p> <p>The security policies are being implemented around locking of the facility from dusk to dawn.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is underfloor electrical. Staff stated that this is effective. Residents interviewed confirmed the temperature was good. The facility has a designated smoking area but there are no residents who currently smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control coordinator is an RN who has completed an infection control course. The infection control coordinator oversees infection control for the facility and is responsible for the collation of infection events. The infection control coordinator has a defined job description. Infection events are collated monthly and reported to combined infection control and health and safety.</p> <p>The infection control programme has been developed by the CHT management team infection control team and is linked to the quality system.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator has attended external infection control and prevention control education, including DHB infection control nurse meetings, and she leads the infection control focus group.</p> <p>The combined infection control/health and safety committee form part of the quality risk committee. The committee meets monthly and discuss infection control events and quality data as evidenced in meeting minutes.</p> <p>The infection control coordinator has access to GPs, local laboratory, the infection control nurse specialist at the DHB and public health departments at the local DHB for advice and an external infection control consultant specialist.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the</p>	FA	<p>The infection control policies include a comprehensive range of standards and guidelines, including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are reviewed regularly by the CHT senior management team.</p>

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Resident education is expected to occur as part of providing daily cares as appropriate.
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	The infection control coordinator/RN oversees infection surveillance for the service. Surveillance is an integral part of the infection control programme and is described in CHTs infection control manual. Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends and analysis of infection events, outcomes and actions are discussed at the combined quality/health and safety and infection control meetings. Results from laboratory tests are available monthly. There have been no outbreaks.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit there were three with restraints in use (lap belts) and one resident with a lap belt as an enabler. The resident file was reviewed for enabler use and identified the resident had given voluntary consent.
Standard 2.2.1: Restraint	FA	A registered nurse is the restraint coordinator with a defined job description, she also leads the restraint focus

<p>approval and processes</p> <p>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.</p>		<p>group. Restraint discussion and quality data around restraint and enabler use is included in the quality/risk meetings and clinical meetings. Care staff receive education on safe restraint use at orientation and annually. There is ongoing education including challenging behaviours.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. The RN in partnership with the restraint coordinator, the resident and their family/whānau undertakes assessments. Ongoing consultation with the resident and family/whānau are evident. A restraint assessment form had been completed for three resident files reviewed requiring restraint (sighted). Assessments identify risks related to the use of restraint and the specific interventions or strategies to try (as appropriate) before implementing restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Each episode of restraint is monitored at pre-determined intervals, depending on individual risk to that resident.</p> <p>Restraint use is recorded in the care plan; however, risks and cares to be carried out during the restraint episode are not well documented (link to 1.3.5.2). Individual restraint monitoring booklets evidence that checks and cares have been carried out according to the documented frequency described in the monitoring tool. There is an up-to-date restraint register.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluations occur six monthly as part of the ongoing review for residents on the restraint register, and as part of their care plan review. Families (where possible) and the GP and RNs are included as part of this review.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Restraint usage is monitored regularly. The review of restraint use is discussed at the quality risk meetings and relevant facility meetings. The facility is proactive in minimising restraint. Internal restraint audits are completed six monthly and demonstrate compliance of the standard.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	Seven resident files were reviewed, three hospital level, two dementia care and two rest home. All seven residents had a care plan documented. Interventions were documented, but were not always individualised to accommodate all assessed resident need. Staff interviewed, however, were knowledgeable regarding resident care needs. The risks for the use of restraint and enablers was not included in care plans.	One of three hospital files, and one of three rest home files did not include all interventions to support all aspects of assessed needs. Examples include; one hospital resident identified with diabetes instructed to monitor BSLs. There were no accepted blood sugar levels identified. One rest home resident care plan instructed staff to ‘reassess medications’ and ‘avoid constipation’ but no specific interventions and how to do this. The risks associated with restraint and enabler use was not routinely documented in the care plan.	<p>To ensure that all resident care plans include interventions to support all resident assessed needs. Ensure interventions are documented to manage the risks associated with restraint and enablers.</p> <p>90 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>	<p>PA Low</p>	<p>Monitoring charts are available for a variety of monitoring needs such as weight, neurological observations, repositioning and vital signs. Care plans document monitoring needs and care staff state that all residents are informally monitored at all times. Not all monitoring is documented as occurring.</p>	<p>(j) One hospital resident (identified as having swollen legs) care plan instructs staff to monitor twice daily. There was no recording of monitoring of swollen legs.</p> <p>(ii) Two residents who required neurological observation post fall did not have these documented according to set time frames.</p>	<p>Ensure monitoring is completed as per care plan instructions.</p> <p>90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.