

CHT Healthcare Trust - Haldene Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	CHT Healthcare Trust
Premises audited:	Haldene Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 17 July 2018 End date: 18 July 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:	25

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

CHT Halldene is owned and operated by the CHT Healthcare Trust. The service currently provides care for up to 37 residents requiring hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 25 residents. This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff, management and general practitioner.

A unit manager, who is well qualified and experienced for the role oversees the service and is supported by a clinical coordinator and the area manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

This audit has identified areas requiring improvement around care planning and the environment.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff at CHT Halldene strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted, and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents/family meetings have been held regularly. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. An education and training programme has been implemented with a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The clinical coordinator manages entry to the service with assistance from the registered nurses. Comprehensive service information is available. A registered nurse completes initial assessments, including interRAI assessments. The registered nurses complete care plans within the required timeframe. Care plans are clearly written, and health care assistants report they are easy to follow. Residents and relatives 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 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.		Some standards applicable to this service partially attained and of low risk.
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The building has a current warrant of fitness and emergency evacuation plan. Reactive and planned maintenance is in place. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy and have either their own ensuites or a shared ensuite toilet. There are sufficient communal showers. There is sufficient space to allow the safe movement of residents around the facility using mobility aids. There are communal dining rooms and lounges and several smaller seating areas. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning contractors and laundry staff are providing appropriate services. Emergency systems and equipment are in place in the event of a fire or external disaster. There is a first aider on duty at all times.

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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CHT Halldene has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were three residents with four restraints and one resident with an enabler. Restraint management processes are adhered to.

Infection prevention and control

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



Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	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>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with ten staff (three health care assistants, one registered nurse (RN), one activities coordinator, one cook, one kitchenhand, one cleaner, one clinical coordinator and one-unit manager) confirmed their familiarity with the Code. Interviews with six residents (three rest home and three hospital) and two families (both hospital) confirmed the services being provided are in line with the Code. The Code is discussed at resident and staff meetings.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general consents including outings and indemnity forms, were included in the admission process as sighted in resident's files reviewed. Consent forms are signed for any specific procedures.</p> <p>Healthcare assistants interviewed confirmed consent is obtained when delivering cares. Advance directives sampled, identified the resident resuscitation status and/or signed by the resident (if appropriate) and the general practitioner.</p> <p>Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Admission agreements were sighted for the long-term residents.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff and residents informed they are aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are encouraged to be involved in community activities and maintain family and friend networks. On interview, staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of complaints process. There are complaint forms available throughout the facility. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a complaints' register. There were nine complaints made in 2017 and three year-to-date. All complaints reviewed had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. Discussions with residents confirmed that any issues are addressed, and they feel comfortable to raise any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters of the code of rights on display throughout the facility and leaflets are available in the foyer. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the unit manager discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code of Rights.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p>	FA	<p>The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage to maintain privacy and respect of personal property. All residents interviewed stated their needs were met.</p>

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.		A policy describes spiritual care. Church services are held on a regular basis. All residents interviewed indicated that residents' spiritual needs are being met when required.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. There were no Māori residents on the day of audit. Cultural and spiritual practice is supported, and identified needs are incorporated into the care planning process. Staff have received training on the Treaty of Waitangi. Discussions with staff confirm that they are aware of the need to respond to cultural differences.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including residents' cultural beliefs and values, is used to develop a care plan. Staff receive training on cultural awareness.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The service has a staff code of conduct, which states there will be zero tolerance against any discrimination occurring. The registered nurses supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies to guide practice that aligns with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Staffing policies include the requirement to attend

		<p>orientation and ongoing in-service training.</p> <p>The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. The unit manager is responsible for coordinating the internal audit programme. Qlik Sense, a new tool, is used to extract data from VCare and analyse incidents, infections, falls, unintended weight loss, pressure injuries, skin tears and complaints. This extract is used to assist in implementing strategies to reduce further events. Evidence-based practice is evident, promoting and encouraging good practice. The service has links with the local community and encourages residents to remain independent. Residents and relatives interviewed spoke positively about the care and support provided.</p> <p>Last Days of Living care plans are utilised improving standard of palliative care delivered. This was combined with a case study on palliative care, completed by the Clinical Co-ordinator in early 2017.</p> <p>The service is in currently building of a new facility to provide future residents with a more aesthetically pleasing environment and individual ensuite rooms for those who previously did not have one. Building (stage 1) due for completion August 10, 2018.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy around open disclosure alerts staff to their responsibility to notify family/next of kin of any accidents/incidents that occur. Ten incidents/accidents forms were reviewed for June and July 2018. The forms included a section to record family notification. All forms indicated family were informed or if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>CHT Halldene is owned and operated by the CHT Healthcare Trust. CHT purchased the service in October 2014. The service provides rest home and hospital level care for up to 37 residents. On the day of the audit, there were 25 residents in total, 7 rest home level and 18 hospital level. This includes one hospital resident on a long-term chronic health contract. All rooms are dual-purpose. Bed numbers are currently down in preparation for a move to a new adjacent purpose-build building which is near completion.</p> <p>The unit manager is a registered nurse and maintains an annual practicing certificate. She has been in the manager role at the facility for over four years and continued as unit manager when CHT purchased the service. A clinical coordinator who has been in the position for ten months supports her. The unit manager reports to the area manager weekly on a variety of operational issues. CHT has an overall</p>

		<p>business/strategic plan and CHT Halldene has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement.</p> <p>The unit manager has completed in excess of eight hours of professional development in the past 12 months.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the absence of the unit manager, the clinical coordinator is in charge, with support from the area manager, registered nurses and care staff.</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>There is an organisational business/strategic plan that includes quality goals and risk management plans. Interviews with staff confirmed that quality data is discussed at monthly staff meetings to which all staff are invited. The unit manager advised that she is responsible for providing oversight of the quality programme. The quality and risk management programme is designed to monitor contractual and standards compliance. 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. Resident/relative meetings are held monthly. Restraint and enabler use is reported within the clinical and staff meetings.</p> <p>Data is collected in relation to a variety of quality activities and a comprehensive six monthly internal audit was last completed in March 2018. Areas of non-compliance identified through quality activities are actioned for improvement.</p> <p>The service has identified a number of annual quality goals. The following goals have identified improvement including (but not limited to); (i) reducing pressure injuries. These have declined with better staff education and supervision. Work on this is ongoing. (ii) Reduce the number of falls – this has been achieved overall. (iii) Reduce the number of restraints – this has been achieved. And (iv) Reduce the numbers of people with unintended weight loss – overall this is improving.</p> <p>The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. An annual residents/relatives' satisfaction survey for 2017 and 2018 shows consistently high results in most</p>

		areas (90% or higher).
<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 investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly clinical and staff meetings including actions to minimise recurrence. Ten resident incident forms sampled demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Discussions with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There was appropriate notification made around a gastric outbreak in October 2017 and an unstageable pressure injury.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files were reviewed (one clinical coordinator, one registered nurse, one activities coordinator and two health care assistants) and evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all 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 2017 has been completed and a plan for 2018 is being implemented. The unit manager and registered nurses are able to attend external training, including sessions provided by the local DHB. All six of the six registered nurses (including the UM and CC) have completed interRAI training.</p> <p>The service has upgraded their Moving and Handling Programme. This has resulted in a more thorough orientation around moving and handling and this is delivered by Halldene's moving and Handling team which consists of the clinical co-ordinator and two healthcare assistants supported by the physiotherapist.</p> <p>The service has increase the number of staff who are CareerForce trained. Their clinical co-ordinator has been trained as an assessor.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service</p>	FA	<p>Policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. There is a minimum of one RN on-site at any time. Activities are provided seven days a week. Staff working on the days of the audit, were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall</p>

<p>from suitably qualified/skilled and/or experienced service providers.</p>		<p>the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed reported there are sufficient staff numbers.</p> <p>CHT Halldene rosters three areas separately - upstairs, right wing and lower wing. The RN and staff in the right and lower wings are also available to assist in opposite areas as required.</p> <p>The upstairs wing has 13 current residents (seven hospital and six rest home). The morning shift is covered by the clinical coordinator, and two healthcare assistants (one long shift and one short shift). On the afternoon shift, one RN and one HCA work the full shift. At night an RN and an HCA work the full shift.</p> <p>The right wing has six current residents (all hospital). The morning shift is covered by the clinical coordinator, and one healthcare assistant from 7.00 am to 12:30 pm. Staff from the lower wing provide cover when the HCA finishes their shift. On the afternoon shift, one HCA works the full shift with support from the RN based upstairs. At night an HCA works the full shift.</p> <p>The lower wing has six current residents (five hospital and one rest home). The morning shift is covered by support from the clinical coordinator, and one health care assistant from 7.00 am to 3.00 pm. On the afternoon shift, one HCA works the full shift with support from the RN based upstairs. At night an HCA works the full shift.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant health care assistant or registered nurse.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services provided, the admission process and entry to the service. Residents interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager and clinical coordinator. The admission agreement aligns with the requirements of the DHB contract.</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>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the DHB hospital transfer form and yellow aged care envelope system. Relatives are notified if transfers occur.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual medication orders with photo identification and allergy status documented on the electronic system. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Medication orders include indications for use of 'as needed' medicines. Short-life medications (ie, eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and senior health care assistants with medication administration responsibilities. Ten medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. A registered nurse was observed administering medications and followed correct procedures. There were no residents self-administer medicines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>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 is provided to the kitchen staff. The kitchen can meet the needs of residents who require special diets. Kitchen staff have completed food safety and chemical safety training. The kitchen manager and cooks follow a 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 food is fortified for residents with weight loss. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were happy with the quality and variety of food served.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the</p>	FA	<p>The service records the reasons for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Information on alternate placement options is provided.</p>

immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files sampled demonstrated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools were completed, and the outcomes of assessments were reflected in the long-term care plans in resident files reviewed. The InterRAI assessment tool has been completed for all residents. The InterRAI assessments are completed six monthly or earlier if there are changes to the resident's health status.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	The electronic care planning system is comprehensive and includes all aspects of care. Five care plans were reviewed. The long-term care plans reviewed did not always describe the support required to meet the resident's assessed needs. Residents and relatives confirmed they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Care staff interviewed reported the care plans are readily available and they found the plans easy to follow. HCAs reported that handovers were comprehensive and that they are aware of resident needs.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Registered nurses and HCAs follow the care plan (link 1.3.5.2). RNs report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral as evidenced in resident files. If external medical/specialist advice is required, this will be initiated by the GP. Healthcare assistants report that they are informed of any changes to residents required needs at handover. 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. Wound assessment, monitoring, wound management plans and short-term care plans are in place for nine wounds including two stage two pressure injuries and one grade one pressure injury. The RNs have access to specialist nursing wound care management advice through the district health board (DHB). Appropriate pressure injury interventions were documented in the care plans of residents identified as high risk of pressure injury and with a pressure injury. Blood sugar monitoring, regular weight monitoring, turning charts and intake and fluid balance charts were in use were documented. Pain monitoring was documented as needed and one resident with

		oxygen therapy was being monitored as needed.
<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>	FA	<p>A team of two activity coordinators are employed to deliver the activities programme seven days a week. The activities provided meet the recreational preferences and abilities of the resident groups and include arts 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 lounges. 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. All long-term resident files sampled have 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>Wifi has been introduced to facilitate communication between residents and contractors with outside parties. Theme Days – CHT has introduced various theme days to support the activities programme. Special menus are organised, and posters, tablecloths and decorations provided to build the theme around</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 long-term care plan is evaluated at least six monthly or earlier if there is a change in health status, using the electronic care planning system. Care plan evaluations are documented and include reporting progress on meeting goals. All changes in health status are documented and followed up. Six monthly reassessments have been completed by RNs using interRAI for all residents and for those who have had a significant change in health status. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.</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</p>	FA	<p>The service facilitates access to other medical and non-medical services such as dietitian, and mental health for older persons. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. Staff provided an example of where a resident's placement at the service was of concern and the resident was in the process of being reassessed (link to 1.1.13).</p>

<p>provided to meet consumer choice/needs.</p>		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety datasheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The building has a current building warrant of fitness displayed. There is a maintenance person who works one day a week and as needed. There is a reactive maintenance communication book and a planned maintenance plan in place for the internal and external building. All electrical equipment is tested and tagged two yearly. Clinical equipment is checked and calibrated annually. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The service is on two levels with a lift and stairs between floors. The service has shortcomings identified around the general environment, the kitchen environment, the carpets and bathrooms.</p> <p>The facility has sufficient space for residents to mobilise using mobility aids. External areas are well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares, as outlined in the resident care plans.</p> <p>The service has sufficient equipment to meet the needs of current residents and sufficient equipment including suction and oxygen equipment, to meet the needs of medical level hospital residents.</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</p>	<p>FA</p>	<p>There are an adequate number of communal toilets and shower/bathing areas for residents. All communal toilets and shower rooms have vacant/engaged slide signs (link to 1.4.2.1). Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>

assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All residents' rooms are of an appropriate size to allow cares to be provided for the assessed level of care and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	The communal areas include a large open plan lounge and smaller seating areas. Activities take place in a number of areas throughout the facility. There is a rest home and hospital resident dining room. Communal rooms are easily accessible.
<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>	FA	All laundry and cleaning are done on-site by a contracted service. A laundry/cleaning supervisor oversees the service. The laundry has entry and exit doors and there are defined clean/dirty areas. Cleaning trolleys are well equipped and are stored safely when not in use. Staff have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness and laundry process is monitored through the internal audit programme.
<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>	FA	<p>The fire evacuation plan has been approved by the fire service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. Fire training and security situations are part of orientation of new staff and include competency assessments. There are adequate supplies in the event of a civil defence emergency including food, water and gas cooking. Short-term back-up power for emergency lighting and the call bell system is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available always.</p> <p>There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to</p>

		have their call bells near. The building is secure after hours.
<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	General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.
<p>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	CHT Halldene has an infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse (also the CC) is the designated infection control coordinator with support from the unit manager and all staff as the quality management committee (infection control team). Minutes are available for staff. Regular six monthly internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.
<p>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	A registered nurse at CHT Halldene is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme, for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team, bug control and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice</p>	FA	There are CHT infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.

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 policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance is described in CHTs infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the facility meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the unit manager. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There were three residents with restraint and one resident with an enabler. One resident uses both bedrails and a lapbelt. All other restraints and the enabler are bed rails. One enabler file sampled documented that enabler use is voluntary. All necessary documentation has been completed in relation to the restraints. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff training/education on restraint/enablers has recently been provided in May 2016. Restraint is discussed as part of staff meetings. A registered nurse is the designated restraint coordinator.
Standard 2.2.1: Restraint approval and processes	FA	A registered nurse is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner. Interviews with the HCAs and nursing staff confirmed their understanding of restraints and enablers. Staff

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.		training around restraint minimisation and management of challenging behaviours last occurred in April 2018.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the files reviewed (three restraint and one enabler), assessments and consents were fully completed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified, and approval processes are obtained/met. An assessment form is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular monitoring at the frequency determined by the risk level were present in the files reviewed. The service has a restraint and enablers register, which is updated each month.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. Evaluation timeframes are determined by policy and risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. The restraint coordinator and unit manager complete the restraint review. Any adverse outcomes are reported at the monthly staff meetings. Restraints have been reviewed successfully with a consequent drop in the number of these by up to 50% (most recent months).

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 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	Care plans had been completed by registered nurses using the assessment process integrated within the electronic care planning system. Caps identified from interRAI assessments were reflected into care plans. The interventions to manage identified issues were not always documented.	(i) Three resident care plans (one rest home and two hospital) did not reflect the management strategies to support and manage residents with behaviours that challenge/anxiety. (ii) One hospital care plan did not document interventions to support the risks associated with warfarin use.	(i)-(ii) Ensure that interventions are documented to support all identified risks and needs. 90 days
Criterion 1.4.2.1	PA Low	The service is in the process of building a new facility and plans to move within the next two	The service has shortcomings identified around the general environment, the kitchen	Ensure that the

<p>All buildings, plant, and equipment comply with legislation.</p>		<p>months. All areas in the existing facility are clean and safe, but not all are in a good state of repair.</p>	<p>environment, the carpets and bathrooms. All areas are safe and clean, however not all are in a good state of repair. The service is building a new facility next door and expects to move in the next two months.</p>	<p>environment continues to remain safe until the move to the new facility.</p> <p>180 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.