

CHT Healthcare Trust - Hillcrest 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:	Hillcrest Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
Dates of audit:	Start date: 13 September 2018 End date: 14 September 2018
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	69

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Hillcrest Hospital is part of the CHT group of facilities. The facility is purpose-built, providing four levels of care hospital – geriatric/medical, rest home, dementia and residential disability – physical for up to 80 residents. On the day of audit there were 69 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.

This audit identified an improvement required around care plan interventions.

The service is commended for achieving two continued improvement ratings around good practice and community involvement.

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.		All standards applicable to this service fully attained with some standards exceeded.
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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 stated 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 and a performance plan with goals for the service that has been regularly reviewed. Hillcrest 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 welcome pack that contains information on the services and levels of care available at CHT Hillcrest. Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information gained through the discharge summaries, interRAI assessments, and care plans and evaluations to guide staff in the safe delivery of care to residents. The care plans are resident, and goal orientated and reviewed every six months or earlier if required with input from the resident/family as appropriate. Allied health and a team approach are evident in the resident files reviewed. The general practitioner reviews residents at least three monthly.

The activity coordinators implement the activity programme in the rest home/hospital and dementia care units to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are entertainers, outings, and celebrations.

Medications are managed appropriately in line with accepted guidelines. The registered nurses and senior health care assistants administer medications and have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner.

All meals are cooked onsite by a contracted service. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Nutritional snacks are available 24 hours.

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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The building has a current warrant of fitness. There is a reactive and planned maintenance programme in place. Chemicals are stored safely throughout the facility. All resident rooms are single with ensuites. Each pod (of 10 beds) has a kitchenette and open plan dining and lounge area. There is sufficient space to allow the movement of residents around the facility using mobility aids. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaners and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or other emergency. There is a first aider on duty at all times. Laundry is completed onsite.

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 four residents with restraints in use (all bed rails) and nine residents with seven bedrails and two lap belts as an enabler. Staff receive training around restraint and challenging behaviours.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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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	1	48	0	1	0	0	0
Criteria	2	98	0	1	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. Four residents (three hospital including one younger person and one rest home level of care) and seven relatives (six hospital level and one rest home) interviewed, confirmed that information has been provided around the code of rights. Residents stated that their rights are respected when receiving services and care. Discussion with 13 caregivers, five registered nurses (RN) and one activities coordinator 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>Informed consent processes are discussed with residents (as appropriate) and families on admission. Written consents form part of the admission agreement for permissions granted. Nine resident files reviewed (five hospital including one younger resident with a physical disability and one resident under primary option acute care contract (POAC), two rest home residents including one younger person under the long-term stay chronic health condition (LTS-CHC) and two dementia care resident files), demonstrated that consents had been signed. Resuscitation forms for the competent resident had been signed by the resident and general practitioner (GP). There was evidence of discussion with family when the GP had completed a clinically indicated not for resuscitation order. Copies of enduring power of attorney (EPOA) where available were sighted in the resident file. The EPOA had been activated in the two dementia care files reviewed.</p>

consent.		Thirteen health care assistants (HCAs) and four registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All long-term files had signed admission agreements. The resident under POAC funding had signed a short-stay agreement.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	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. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy services. Staff receive education and training on the role of advocacy services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The service has an open visiting policy and family/whānau and friends are encouraged to visit the home and are not restricted to visiting times. All residents interviewed confirmed 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. Hillcrest has implemented a number of initiatives around community involvement.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available and visible at the entrance to the facility. Information about complaints is provided on admission. Interviews with residents and family confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. There is a complaint register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system. There have been ten resident/relative complaints for 2017 (including one received from the DHB) and ten complaints (year to date) for 2018. 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. Discussion around concerns, complaints and compliments are evident in quality, clinical and staff meeting minutes. The unit manager has responded and met with families as required. The area manager was involved in the management of the DHB complaint. Corrective actions related to this complaint have been implemented and remain in place.

<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 stated they receive sufficient verbal and written information to be able to make informed choices on matters that affect them. There is specific information around dementia care provided to relatives and visitors. An annual resident/relative satisfaction survey is completed. Surveys include young people with disabilities around issues relevant to this group. There were no issues identified in their last survey.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The 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 residents' 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. Young people with disabilities can maintain their personal, gender, sexual, cultural, religious and spiritual identity. There are a variety of resident contracts; however, interviews and evidence confirmed that all residents are getting appropriate individualised care despite the mix.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are cultural awareness policies and a Māori health plan to guide staff in the delivery of culturally safe care. The facility is involved with the local community Turehau Māori wardens. The Kaumātua provides blessing for the site and prayers as needed. There were several residents who identify as Māori on the day of audit. Staff interviewed were knowledgeable about specific Māori cultural values and beliefs.</p>
<p>Standard 1.1.6: Recognition And Respect</p>	FA	<p>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,</p>

<p>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>		<p>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 onsite.</p>
<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. Staff job descriptions include responsibilities and professional boundaries. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with staff across all areas confirmed an awareness of professional boundaries. 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>CI</p>	<p>All CHT facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly at head office by the appropriate person. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. Care staff and registered nurses (RNs) have access to internal and external education opportunities. A range of clinical indicator data are collected against each service level and reported through CHT head office for collating, monitoring and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type, and resident and relative satisfaction. Regular facility and clinical meetings and shift handovers enhance communication between the teams and provide consistency of care.</p> <p>The service contracts a physiotherapist for eight hours per week, 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 gardening project involving residents and the community, a falls management project, a challenging behaviour project, an RN training plan which achieved a CHT merit award, and case studies on pressure injury and falls management. The service has been successful in reducing falls.</p>
<p>Standard 1.1.9:</p>	<p>FA</p>	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a range of information regarding the scope of service provided to the resident and their family on</p>

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>entry to the service. The information pack is available and can be read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Regular contact is maintained with family, including if an incident or care/health issues arises. Evidence of families being kept informed is documented in the electronic database and in the residents' progress notes. All family interviewed stated they were well-informed. Incident/accident documentation reviewed indicated that the next of kin are routinely contacted following an adverse event. Regular resident and family meetings provide a forum for residents to discuss issues or concerns. Access to interpreter services is available if needed for residents who are unable to speak or understand English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Hillcrest Hospital is part of the CHT group of facilities. The building is a purpose-built facility providing hospital - geriatric/medical, rest home, dementia and residential disability (physical) level care for up to 80 residents. On the day of audit there were 69 residents. There were 47 hospital (including six on younger persons disability(YPD) contracts, four on long-term stay chronic health (LTS-CHC) and one primary option acute care contract (POACC) and six rest home level residents (including one LTS-CHC) in the 60-bed dual-purpose unit and 17 in the 20-bed secure dementia unit. All other residents were under the age-related residential care services agreement.</p> <p>A CHT business plan for 2018 – 2023 with a strategic theme has been developed and includes business plan targets. Hillcrest Hospital has set a number of quality goals within the unit manager performance plan and these also link to the organisation's strategic goals. The service has a philosophy of care which encompasses a resident family centred approach for younger residents.</p> <p>The unit manager has been in this role for four years and has completed several papers towards a postgraduate diploma in Health Service Management. He has been involved in aged care in NZ for six years. He is supported by a clinical coordinator who is new to the role and an experienced area manager. The Ministry of Health has been notified of the change in clinical 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</p>	<p>FA</p>	<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>effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>CHT has a well-established and comprehensive quality and risk programme directed by head office, based in Auckland. There are policies and procedures appropriate for service delivery including the specific needs of younger people. Policies and procedures are reviewed regularly by head office key staff who ensures they align with current good practice and meet legislative requirements. Policies changes are communicated to staff at monthly meetings.</p> <p>Discussions with the management team and review of management and staff meeting minutes, demonstrated their involvement in quality and risk activities. 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. Three monthly quality and monthly staff and clinical meetings document staff discussions around accident/incident data, health and safety, infection control, and concerns. Minutes of meetings are posted in the staff room for all staff to read.</p> <p>The service has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Clinical indicators are graphed and displayed in the staff room, showing trends in the data. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Interviews with care staff confirmed their awareness of clinical indicator trends and strategies being implemented to improve residents' outcomes.</p> <p>Residents are surveyed regularly to gather feedback on the service provided and survey results are communicated to staff, residents and families. Corrective actions are implemented where ratings indicate lower than anticipated results. The last survey was overall very good. Although responses to food services identified ongoing issues. A corrective action continues to be in place with compass recently hiring a new head chef and frequent meetings occurring with the UM and compass management to address the issues.</p> <p>Health and safety policies are implemented and monitored. Three enthusiastic and knowledgeable health and safety officers (all senior caregivers) were interviewed. All three have completed external health and safety training up to stage three. Health and safety inspections and hazard register reviews occur monthly and the health and safety officers communicate between each other on a monthly basis. Equipment including (but not limited to): wheelchairs, walkers, hoists and shower chairs are checked and followed through to ensure repairs have been actioned. Mandatory three-monthly health and safety facility meetings are held.</p> <p>Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses</p>

		incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Falls management strategies include assessments after falls and individualised strategies.
<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>Thirteen 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. 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. The service has submitted section 31 and outbreak notifications as required.</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 resources policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Seven staff files were reviewed (three RNs, three HCAs and one activities coordinator). All files contained relevant employment documentation including orientations. Senior (experienced) HCAs described a mentoring programme for the new, less experienced HCAs. The education planner 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. All eleven RNs are interRAI competent. Staff complete competencies relevant to their roles. Staff training has included sessions on privacy/dignity, spirituality/counselling, code of rights, activities and social media to ensure the needs of younger residents are met.</p> <p>All 14 caregivers working in the dementia unit have completed dementia units. All RNs have a current first aid certificate.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and</p>	FA	<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 unit manager and clinical coordinator are on duty during the day Monday to Friday. Both share the on-call requirement for clinical concerns.</p>

<p>safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>Registered nurses have sufficient time available to complete interRAI assessments and care planning evaluations within contractual timeframes. Interviews with residents and family members identified that staffing is adequate to meet the needs of residents.</p> <p>The hospital/rest home dual-purpose beds are split evenly into six wings of ten beds each (Amaryllis, Daisy, Frangipani, Hibiscus, Magnolia and Rose wings). At the time of the audit there were five rest home and 47 hospital residents across the six dual-purpose wings. The dementia (Garden) wing is separated into two, ten bed wings with a total of 17 occupied at the time of audit.</p> <p>In the hospital/rest home area there are two RNs on duty on the morning shift covering three wings each and one RN covering the dementia unit. In the afternoon, two RNs cover three dual-purpose wings each and one wing each from the dementia unit. On night shift one RN covers the facility. Healthcare assistants are staffed according to units;</p> <p>Amaryllis (two RH and five hospital) AM one long shift HCA and one short shift HCA; PM one long shift HCA and night shift one HCA shared across Amaryllis, Daisy and Frangipani.</p> <p>Daisy (three RH and five hospital) AM one long shift HCA and one short shift HCA; PM one long shift HCA and night shift</p> <p>Frangipani (ten hospital) AM one long shift HCA and one short shift HCA; PM one long shift HCA.</p> <p>Hibiscus (seven hospital) AM one long shift HCA and one short shift HCA; PM one long shift HCA and night shift one HCA shared across Hibiscus, Rose and Magnolia.</p> <p>Magnolia (ten hospital) AM one long shift HCA and one short shift HCA; PM one long shift HCA.</p> <p>Rose (ten hospital) AM one long shift HCA and one short shift HCA; PM one long shift HCA.</p> <p>Garden wings (dementia two wings rostered as one; 17 residents) For the AM there are three long-shift HCAs and one short-shift HCA, PM three long shifts HCAs and night two long shifts HCAs.</p> <p>Residents and relatives stated there are adequate staff on duty at all times. Staff stated they feel supported by the management team who respond quickly to after hour calls.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded,</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>

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>The service has admission policies and processes in place. Residents receive an information pack outlining the services able to be provided including information on dementia level of care. The unit manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the unit manager or clinical coordinator.</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 admission to hospital are managed appropriately and relevant information is communicated to the DHB. 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 policies and procedures comply with medication legislation and guidelines. Medicines are stored safely in two medication rooms (rest home/hospital and dementia unit). The service uses an electronic medication system. Registered nurses and senior HCAs are responsible for medication administration and complete annual medication competencies and annual medication education. Registered nurses have completed syringe driver competencies through the hospice. Robotic medication rolls are checked on delivery by the RN on duty. There is an impress stock and bulk supply order (for hospital level residents) which is checked weekly for expiry dates. Eyedrops are dated on opening. The medication fridge is checked weekly and temperatures are within acceptable ranges. There were no residents self-medicating on the day of audit.</p> <p>Eighteen medication charts on the electronic medication system were reviewed. All charts met prescribing requirements including the indication for use of 'as required' medications. All charts had photo identification and allergy status.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals and baking is done onsite by a contracted service. The multi-site manager (interviewed) is responsible for the operations of the food services including recruitment, rosters and training. A food control plan has been submitted April 2018 and yet to be verified. Staff have completed food safety training. The main chef is on duty 9.00 am to 5.30 pm and is supported by kitchen assistants. The four-weekly menu has been reviewed by the contracted dietitian and CHT dietitian. The main meal is at midday with a lighter meal in the evening. The menu provides vegetarian options, soft/pureed options and accommodates ethnicities around beef and pork. Fortified foods (REAP) is provided for residents with identified weight loss and as instructed by the RN/dietitian. Breakfast is prepared and served by HCAs in the dining rooms of each pod of 10 beds. Meals are delivered in covered dishes in scan boxes to some of the pods and are plated and delivered on trays to other pods. There is specialised crockery and cutlery for use as required. Red plates are used in the dementia unit to assist residents at meal times. There are snacks available across 24/7. Resident food allergies and dislikes are known. The service uses the international colour coding to identify special diets and allergies.</p> <p>The temperatures of refrigerators, freezers and end cooked foods are monitored and recorded daily. All food is stored appropriately. A cleaning schedule is maintained. Residents have the opportunity to provide feedback at resident meetings and surveys. Resident feedback has identified an opportunity for the food service to provide specific menus around meeting ethnic dietary preferences. The service continues to work through corrective actions with compass.</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>	<p>FA</p>	<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 and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p>	<p>FA</p>	<p>Resident files reviewed indicated that all appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. Files reviewed, contained applicable risk assessment tools and these assessments were reviewed at least six monthly or, when there was a change to a resident's health condition. The interRAI assessments have been completed for the long-term residents and care plans were developed based on these assessments. Assessments for management of behaviour were</p>

gathered and recorded in a timely manner.		completed in the two dementia resident files sighted with interventions including activities. Additional assessments were completed as required such as wound assessments and restraint assessments. The activity coordinators complete an activity assessment on admission for all residents including the younger people, which identifies their individual interests, hobbies and links with the community.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>Long-term care plans for permanent residents had been completed within three weeks. Long-term care plans reflected the resident's current needs/supports to achieve the resident goals for six of eight long-term resident files reviewed. The resident under POAC funding has a short-term care plan in place. The interRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning process. The care plans in the dementia files reviewed include behaviour management plans that identify the resident's behaviours, triggers and de-escalation techniques including management activities. The care plans for younger people reflected individual choice including daily activities of living and interests and hobbies. Short-term care plans are in use for short-term needs including infections. Short-term care plans are evaluated regularly and either resolved or if an ongoing problem transferred to the long-term care plan. Care plans identified allied health input into the resident's care including the dietitian, podiatrist, physiotherapist, gerontology nurse specialist, specialist wound care nurse, and the mental health team.</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>	FA	<p>Registered nurses (RNs) and healthcare assistants (HCAs) follow the care plan and report progress against the care plan each shift at handover. If a resident's condition changes the RNs will initiate a GP or nurse specialist referral. Relatives interviewed confirmed they were notified of any resident health changes.</p> <p>Staff have access to sufficient medical supplies and dressings. Wound assessment, wound monitoring, and wound evaluations are in place for current wounds including one community acquired stage three pressure injury and one stage two facility acquired pressure injury. Documentation and photos monitor healing progress. The wound nurse specialist has been involved with the management of the stage three pressure injury.</p> <p>Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available through the DHB.</p> <p>There was evidence of monitoring a resident's health status such as two hourly turning charts, food and fluid charts, regular monitoring of bowels, monthly weights, blood pressure, blood sugar levels, behaviour, pain and restraint monitoring as required.</p>
Standard 1.3.7: Planned	FA	The service employs two activity coordinators (30 hours a week each) and a weekend coordinator to implement

<p>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>the separate rest home/hospital and dementia unit programme Monday to Sunday (one has completed level 4 and the other level 3). The activity coordinators rotate a month about between the rest home/hospital and dementia unit. Meaningful activities for residents in the dementia unit include garden walks, checking the mail, arts and crafts, baking, board games and weekly bus trips. One-on-one activities include hand massage, bible reading, sensory activities, foot spa and beauty therapy. The rest home/hospital programme include group morning activities such as exercises, newspaper reading, group strolls, arts and crafts, board games, flower arranging and storytelling. There are one-on-one activities with residents in the afternoons. The service celebrates themes, birthdays and festive occasions. The service contracts a mobility bus for its hospital/rest home residents. Outings includes scenic drives to beaches, parks, cafés, inter-home visits and a visit to the Marae for te reo Māori week. Many family members provide entertainment with singing and dancing. The SPCA pet therapy visits regularly as do school children from the local school and kindergarten. There are three church services held weekly and Holy Communion on Sundays. Residents are involved in the gardening project that provides produce to the community (link CI 1.1.12.2).</p> <p>The younger people in the facility spend time together as a group and spend time with their families. They are aware of the activity programme and choose to attend activities of interest. Many are independent with individual hobbies and interests and mobilise independently with power chairs to do their shopping. Some of the younger people are involved in leading activities such as the crafts group.</p> <p>A lifestyle questionnaire is completed soon after a resident's admission. The RN completes the activity assessment on admission. An individual activities plan is developed for each resident and evaluated six monthly by the RN, activity coordinator in consultation with the resident. Participation is monitored. Residents have the opportunity to feedback on the activity programme through resident meetings and surveys. Residents and relatives interviewed stated they were very satisfied with activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Initial care plans reviewed had been evaluated by the registered nurses within three weeks of admission. The long-term care plans were evaluated at least six monthly or earlier for health changes in six of eight long-term files reviewed. Two residents (one hospital level and one dementia care resident) had not been at the service six months. The short-term resident under POAC funding was not required to have an evaluation. There is a three-monthly multidisciplinary review that includes input from the resident (if appropriate), RN, HCAs, GP, pharmacist, physiotherapist and any other relevant health professionals involved in the care of the resident. The family are invited to attend and are sent a copy of the review if unable to attend. The six-monthly written evaluations (on VCare) record the residents progress against the resident goals. The care plans are updated to reflect changes identified during the review (link 1.3.5.2).</p>
<p>Standard 1.3.9: Referral</p>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained</p>

<p>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>		<p>on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. Evidence of referrals were sighted on the files reviewed.</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. Chemicals sighted were labelled correctly and stored safely throughout the facility. There is no decanting of chemicals. Safety datasheets are readily 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>FA</p>	<p>The building has a current building warrant of fitness that expires 9 March 2019. The maintenance person was on leave and was covered by a relieving maintenance person (interviewed) from another CHT site who was available for more urgent repairs as observed on the day of audit.</p> <p>Reactive and planned maintenance is the responsibility of the property manager. Staff log any items for maintenance and repair into a maintenance book that demonstrates maintenance and repairs are addressed within a timely manner. There is a planned maintenance schedule in place for internal and external building maintenance. Monthly hot water temperature checks of are completed and are below 45 degrees Celsius. Essential contractors are available 24 hours. Equipment has been tested and tagged and clinical equipment calibrated.</p> <p>The facility has sufficient space and wide corridors for residents to mobilise using mobility aids and electric chairs. External areas are well maintained. Residents have safe access to external areas that have seating and shade.</p>

		<p>The dementia unit has an internal walking pathway and an outdoor courtyard with entry and exits doors into the building. The courtyard has seating and shade.</p> <p>Care staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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>Resident rooms in the rest home/hospital have ensuites. There is a large communal bathroom for the use of a shower trolley if required. Residents in the dementia unit share the communal toilets and bathrooms. There are sufficient numbers of communal toilet/showers facilities with privacy signs. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All resident rooms in the rest home/hospital are single and dual-purpose. The rooms are of an appropriate size to be able to provide for hospital level of care residents. Residents can safely move about the room with the use of mobility aids and there is sufficient space for the use of hoists for the safe transfer of residents. Resident rooms in the dementia unit are spacious enough for residents to mobilise safely. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</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</p>	FA	<p>The resident rooms are set out in “pods” of 10 beds each. Each “pod” has a kitchenette and open plan dining room and lounge.</p> <p>Seating and space can be arranged to allow both individual and group activities to occur. There are sufficient communal areas for residents who prefer quieter activities or for visitors. There are outdoor courtyards with seating and shade and raised garden beds.</p>

their relaxation, activity, and dining needs.		
<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	<p>Dedicated cleaners have access to a range of chemicals, cleaning equipment and protective clothing. There are three cleaners a day seven days a week. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility. Cleaning trolleys are stored in a locked cupboard when not in use and have locked chemical boxes built into the trolley. Safety datasheets are available.</p> <p>All laundry is completed in an external commercial laundry set on the same site. The laundry services 11 other CHT sites. The laundry operates from 8.30 am to 8.30 pm. All personal laundry and linen are laundered. There are defined clean/dirty areas for the pickup and collection of laundry. The laundry is well-equipped, and the equipment has been tested and tagged.</p> <p>The cleaning and laundry services are a contracted service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The service has an emergency/disaster procedures manual in place. There is a staff member with a current first aid certificate on duty 24/7. Fire safety training has been provided. Fire evacuation drills have been conducted six monthly with the last fire drill occurring on 21 May 2018. Civil defence, first aid and pandemic/outbreak supplies are available and are checked on a regular basis. Sufficient water is stored for emergency use and alternative heating and cooking facilities (BBQ and gas bottles) are available. There is a generator available if there is a power failure. Emergency lighting is installed. There is an effective call bell system in place. Visitors and contractors sign in at reception when visiting. Security checks are conducted each night by staff.</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>There is underfloor heating throughout the facility. All rooms have external windows that open, allowing plenty of natural sunlight. There is plenty of natural light in the communal areas. Residents and relatives reported the temperature was comfortable.</p>
Standard 3.1: Infection	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</p>

<p>control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>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>	<p>FA</p>	<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 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</p>	<p>FA</p>	<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>

the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>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.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>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 CHT's 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 has been one respiratory outbreak which was confined to one wing. The outbreak was managed appropriately, and notification made to Public Health.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>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 four with restraints in use (bedrails) and nine residents with enablers (seven bedrails and two lap belts).</p> <p>Three resident files were reviewed for enabler use and identified the residents had given voluntary consent.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on</p>	FA	<p>A registered nurse is the restraint coordinator with a defined job description. 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. For every new restraint, a toolbox talk is held with staff to ensure familiarisation with monitoring and responsibilities. There is ongoing education including challenging behaviours.</p>

restraint use and this process is made known to service providers and others.		
<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; including, risks and cares to be carried out during the restraint episode. Individual restraint monitoring evidences 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>	FA	<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>

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	The care plans for six of eight long-term residents, described the current supports to meet the resident’s needs, however for two residents not all interventions had been documented.	a) One younger person with a physical disability did not have the risk of aspiration and need to sit upright during feeds identified on the care plan. Staff stated there have been no incidents; and b) one resident (under LTS-CHC) commenced on insulin did not have the resident’s diabetic status/interventions identified on the care plan.	<p>a) and b) Ensure interventions are documented for changes in health.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.12.2</p> <p>Consumers are supported to access services within the community when appropriate.</p>	CI	<p>Hillcrest provides a home to residents of different nationalities and cultures. The staff and residents are actively involved in promoting a culture of mutual engagement with the local community including hosting a wedding and enabling a resident to play an active part, involvement in international women’s day celebrations with the cook island community, participating in international Day of the Older Person with a celebration involving a local kindergarten, supporting the</p>	<p>CHT Hillcrest identified the benefits of bringing the community into Hillcrest and embarked on a gardening project. Objectives included promoting the resident’s quality of life by encouraging students to participate in daily activities at Hillcrest, giving back to the community, growing healthy organic vegetables, educating children about the nutritional and health benefits and to encourage residents to be involved in the project. The unit manager approached local schools, and two large raised garden beds were built and prepared for planting. School students visited fortnightly for an hour at a time throughout the project, assisting the residents to plant seedlings, water and fertilise the plants and then to harvest them. Children also took the opportunity of reading to the residents during spare time. Hillcrest provided refreshments and a relaxed community environment. Harvested vegetables were donated to the Salvation Army foodbank and to a local marae. This initiative has positive outcomes for all with residents either actively participating in outdoor activities, or simply watching and engaging with children. There is evidence of increased resident involvement and thank you letters from the schools, resident family members, the marae and the salvation army. Some of the residents were motivated to install planter boxes outside their rooms. CHT Hillcrest was a finalist in the excellence in</p>

		Race4Life charitable trust with raffles and implementing a garden project.	care community connections award for this project.
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>In July 2017, there were 30 plus falls a month identified. The service identified an improvement was required around reduction of falls throughout the service, so a quality initiative was developed August 2017. The service has been successful in reducing falls rates by one third since changes were implemented.</p>	<p>To achieve falls reduction the service analysed location and timing of falls and implemented a number of changes. It was identified the incidence of falls was higher than expected at handover times. On further analysis, staff were all receiving handover in the reception area and were not available to supervise residents at this time. Processes were changed with permanent allocation of staff to working areas. On arrival at work staff were directed to their areas of work and instructed to complete a check of the residents before receiving handover. Handover occurred in an area of the lounge where residents could be observed but not be overheard. All falls are fully investigated, medical causes identified and treated, analysed for trends and ongoing education includes manual handling, hoist refreshers, hourly checks and use of equipment such as sensor mats, physiotherapy input and encouragement in exercise programmes and main lounge activities. Care plans are updated with fall prevention strategies and case studies are discussed at clinical meetings. General practitioners are notified of falls and a medical review including medication review is completed.</p> <p>Despite variances due to resident deterioration and new admissions, the service has achieved its goal in reducing falls rates by 30% since changes were implemented. The service continues to review individual strategies for specific residents with new presentations.</p>

End of the report.