

CHT Healthcare Trust - Lansdowne Hospital and 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:	Lansdowne Hospital and 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: 24 September 2018 End date: 25 September 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:	91

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

CHT Lansdowne is owned and operated by the CHT Healthcare Trust and cares for up to 95 residents requiring rest home or hospital level care. On the day of the audit, there were 91 residents.

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

The service is overseen by a unit manager who is well qualified and experienced for the role and is supported by a clinical coordinator who has been in the role for nine months. Residents, relatives and the GP interviewed spoke positively about the service provided.

This audit has identified areas for improvement around informing staff of quality data and associated trends, implementation and sign-off of corrective action plans, attendance at education in-service training, timeframes for completion of documentation, interventions, aspects of medication management and restraint monitoring.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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CHT Lansdowne functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Staff strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. 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. 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.		Some standards applicable to this service partially attained and of low risk.
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The unit manager is a registered nurse and is supported by an area manager, a clinical coordinator, registered nurses and care staff. The quality and risk management programme includes a service philosophy, goals and an internal audit programme. Quality activities are conducted with the aim of generating improvements in practice and service delivery. Resident meetings are held, and residents and families are surveyed. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated. An education and training programme for staff is documented. Appropriate employment processes are adhered to and 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

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is information available for residents and families prior to entry to the service. Residents are assessed prior to entry to the service. A registered nurse is responsible for each stage of service provision at the facility. Communication with family/whānau is documented. Care plans are individually developed with resident and family/whānau involvement included where appropriate, and evaluated six monthly or more frequently when clinically indicated. The interRAI and other risk assessment tools and monitoring forms are available to effectively assess the level of risk and support required for residents. Activities are provided that are meaningful and ensure that the resident maintains involvement in the community. Residents have a choice in their level of participation. Activity care plans are documented for all residents and evaluated six monthly. A medication management system is in place, and medication management policies are documented. All staff have completed annual competencies for medication administration. There are three monthly GP medication reviews. The menu is designed by a dietitian with summer and winter menus. Staff have completed food safety training. Dietary requirements are provided where special needs are required.

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 and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy, most with a shared toilet, though there are a small number with their own ensuite. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of smaller lounge and dining areas throughout the facility. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning contractors 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 external disaster.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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CHT Lansdowne has restraint minimisation and safe practice policies and procedures in place. The staff in-service training programme covers the topics of restraint minimisation and challenging behaviour management. During this audit there was one resident using a restraint and three residents using an enabler.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is a registered nurse. There is a suite of infection control policies and guidelines that meet infection control standards. The infection control programme is reviewed annually. Staff receive annual infection control education. Surveillance is used to determine quality assurance activities and education needs for the facility.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	44	0	5	1	0	0
Criteria	0	94	0	6	1	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’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is being implemented. Discussions with three managers (one area manager, one-unit manager, one clinical coordinator) and sixteen staff (seven healthcare assistants [HCA], three registered nurses [RNs], one enrolled nurse [EN, two activities coordinators, one kitchen manager, one maintenance staff, and one housekeeping staff) confirmed their familiarity with the Code with examples provided of how they apply the Code to their job role and responsibilities. Interviews with twelve residents (four rest home and eight hospital) and ten relatives (three rest home and seven hospital) confirmed that the services being provided are in line with the Code. Aspects of the Code is discussed during 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</p>	FA	<p>There is an informed consent policy. In all ten files sampled, (three rest home [including one resident on respite and one resident on an ACC contract], and seven hospital including one younger person with a disability) general consent forms were signed on file. Staff were knowledgeable around informed consent. Residents and relatives interviewed could describe what informed consent was and knew they had the right to choose. There is an advance directive policy.</p> <p>There was evidence in files sampled of family/EPOA discussion with the GP for a medically indicated not for resuscitation status. In all files sampled, there was an appropriately signed resuscitation plan.</p>

informed consent.		Discussions with relatives demonstrated they are involved in the decision-making process, and in the planning of resident's care. Admission agreements had been signed and sighted for all the files seen.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family with advocacy information. Advocate support is available if requested. Interviews with staff, residents and relatives confirmed that they are aware of advocacy and how to access an advocate.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to be involved in community activities and maintain family and friends' networks. Staff interviewed reported that residents are encouraged to build and maintain relationships. Community links are in place and include; (e.g., visits to the weekly Howick coffee club, a men's group luncheon is provided weekly at the Howick Club, the Chinese cultural group, and the Mustang club). On interview, all residents and relatives confirmed that they are encouraged to remain as independent as they are able, and that visiting can occur at any time.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaint process. Complaint forms are available at two entrances to the facility. Information about the resident's right to lodge a complaint is also provided during the resident's entry to the service. Interviews with residents and families reflected their understanding of the complaint process. Staff interviews confirmed their understanding around the process for reporting a complaint. A complaint register is maintained electronically using VCare with a hard copy folder containing all details relating to each complaint. There have been nine complaints lodged in 2018 (year to date). No complaints have been lodged through HDC or the DHB since their last audit. All complaints have a noted acknowledgement, investigation, corrective actions (where required) and were documented as resolved. Timeframes for responding to each complaint met HDC guidelines. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.
Standard 1.1.2: Consumer Rights	FA	There are posters explaining the Code on display, and leaflets are available in the foyer of the facility.

<p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>The service is able to provide information in different languages and/or in large print if requested. Written information explaining the Code is provided to next of kin or EPOA to read with the resident and discuss. On entry to the service an RN, the clinical coordinator or the manager discusses the information pack with the resident and family.</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 has policies that 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 maintain the residents' privacy and respect the personal property of residents. All residents interviewed stated their needs were being met. Staff were able to describe how they implement policies around abuse and neglect.</p> <p>There is a policy that describes spiritual care. Church services are conducted every Sunday. All residents and relatives interviewed indicated that resident's spiritual needs are being met when required.</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>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan in place. A Māori pastor regularly visits the facility.</p> <p>Discussions with staff confirmed that they are aware of the need to respond to cultural differences. The activities programme incorporates Māori themes including (but not limited to); kiwiana and Māori language week (July 2018), cultural month (August 2018) and celebrating Matariki and Waitangi Day.</p> <p>There was one resident living at the facility who identified as Māori. This resident was not available to be interviewed. The resident's ethnicity was identified in their care plan. No specific cultural needs were identified in their care plan (link 1.3.5.2).</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping to meet the cultural needs of its residents. Brief information (e.g., ethnicity only) is gathered during the resident's assessment to identify any cultural values and/or beliefs (link 1.3.5.2). HCAs reported that they use sign language and translation cards that are provided by families to assist with communication for those residents who have difficulty understanding English.</p> <p>All residents and relatives interviewed reported that they were satisfied that their cultural and individual values were being met.</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 facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff were respectful. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to new employees during their induction includes standards of conduct.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies to guide practice that align with the health and disability services standards. Staffing policies cover pre-employment processes and the requirement for staff to attend orientation and ongoing in-service training (link 1.2.7.5). A sample of returned resident satisfaction surveys reviewed reflected overall satisfaction with the services they receive (link 1.2.3.6). Residents and relatives interviewed spoke positively about the care and support provided. Health care assistants interviewed, confirmed their understanding of the principles of aged care and stated that they feel supported by the management team.</p> <p>Two rest home level residents and seven hospital level residents have advanced care plans completed. A GP visits the facility a minimum of twice per week and is available 24/7 on call. A physiotherapist is onsite two days a week (9.00 am – 1.00 pm) and is involved in the falls prevention programme and manual handling training for staff. Podiatry services are available every six weeks. Links are in place with mental health services for older people. Specialist support is also available for wound care, dietetics and speech and language pathology (e.g., swallowing assessments).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incidents/accidents forms were reviewed. These completed electronic forms include a section to record family notification. All ten forms indicated that family were informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status. Staff could describe how to access interpreter services.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services</p>	<p>FA</p>	<p>CHT Lansdowne is owned and operated by CHT Healthcare Trust. The service provides rest home and hospital level care for up to 95 residents. All beds are dual-purpose beds. On the day of the audit, there were 30 rest home and 61 hospital level residents. This included three residents on short-term respite care (one hospital level interim DHB contract and two rest home level), one younger person with</p>

<p>are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>disabilities (YPD) contract (hospital level) and one resident funded by ACC (rest home level).</p> <p>CHT has an overall business/strategic plan and CHT Lansdowne has developed annual business objectives that link to CHT strategic themes. A quality and risk management programme is in place for the current year. The unit manager's performance plan measures her performance against these goals. Strategic themes and actions to achieve them are regularly reviewed, evidenced in the quality/health and safety meeting minutes.</p> <p>The unit manager is a registered nurse and maintains an annual practicing certificate. She has been working at this facility since 2008 and has been in her current role as unit manager for the past three years. She is supported by a clinical coordinator/RN who has been working at the facility since 2012 and has been the clinical coordinator (permanent, full-time) since January 2018. The unit manager is supported by an area manager/RN.</p> <p>The unit manager has completed in excess of eight hours of professional development annually relating to managing an aged care facility.</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>	<p>FA</p>	<p>In the absence of the unit manager, the area manager is in charge with support from the senior management team, the clinical coordinator 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>	<p>PA Low</p>	<p>The quality and risk management programme is designed to monitor contractual and standards compliance. Interviews with staff confirmed that they are involved in the quality and risk management programmes. Staff interviews also confirmed that they are kept informed, but meeting minutes failed to reflect documented evidence of data being shared with staff.</p> <p>The service's policies are reviewed at a national level with input from the facility staff every two years. New/updated policies are sent from head office and are shared with staff in the quality/health and safety meetings. New policies are also posted in the staff room for staff to read.</p> <p>Resident/relative meetings are held three-monthly. A sample of residents are also surveyed every month regarding their level of satisfaction with the service, but data is not being collated for analysis</p>

		<p>purposes. Instead, surveys are reviewed individually.</p> <p>Data is collected in relation to a variety of adverse events (e.g., complaints, falls, infections, pressure injuries) and an internal audit schedule is completed six-monthly. Monthly and annual trending is completed. Areas of non-compliance identified through the internal audit process identifies areas for improvements, however there was no evidence that corrective actions have been implemented and signed off.</p> <p>The service has a health and safety programme in place. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The health and safety representative interviewed has completed training through stage three. Hazard identification forms are implemented. Hazards are regularly reviewed, and all new staff and contractors are inducted to the health and safety programme. Health and safety is a regular agenda item in staff meetings.</p> <p>Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an accidents and incidents reporting policy.</p> <p>Accidents and incidents are completed electronically by the RN. All 10 incident forms sighted confirmed that clinical follow up of residents is conducted by a registered nurse. Neurological observations are initiated for all unwitnessed falls. Adverse events entered are collated electronically for the purpose of trending data. Monthly meetings with staff failed to indicate that results were discussed (link 1.2.3.6).</p> <p>Discussions with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is evidence of DHB notification following a respiratory outbreak in September 2018. A section 31 report was also completed earlier in 2018 for an ACC adverse event involving a resident.</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>	PA Low	<p>There are human resource management policies in place. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is maintained. Eight staff files that were reviewed (five healthcare assistants (HCAs), two RNs, one clinical coordinator/RN) evidenced that interviews, police vetting, and reference checks were completed. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. Orientation had been completed in all staff files reviewed. Annual staff appraisals were evident in all staff files</p>

		<p>reviewed for staff who had been employed for one year or longer.</p> <p>There is a documented in-service education programme. Healthcare assistants (HCAs) are strongly encouraged to complete the Careerforce aged care education programme. The unit manager and registered nurses are able to attend external training including sessions provided by the local DHB. Attendance at in-service training reflects low numbers of staff attending mandatory in-services.</p> <p>There are 15 RN's in total, eleven RNs have completed their interRAI training (including the clinical coordinator). There is a minimum of one RN available 24/7 with a current CPR/first aid certification. The driver of the van also holds a current CPR certificate (sighted).</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Service policy for CHT includes staff rationale and skill mix. The unit manager and clinical coordinator are both RNs who are rostered Monday – Friday and share an on-call roster.</p> <p>The two rest home wings (eight hospital and thirty rest home level residents) are staffed with one long and one short shift RN on the AM shift and one RN on the PM shift. One RN covers the entire facility during the night shift. Four HCAs are rostered on the AM shift (three long and one short shift), three HCAs are rostered on the PM shift (two long and one short), and one HCA is rostered to the rest home on the night shift.</p> <p>The three hospital wings with 53 residents (all hospital level) are staffed with three RNs on the AM shift (two long and one short shift), and two RNs on the PM shift (one long and one short shift). Eleven HCAs cover the AM shift (six long and five short), seven HCAs cover the PM shift (five long and two short) and three HCAs cover the hospital wings during the night shift. Extra staff can be called on for increased resident requirements.</p> <p>Laundry, cleaning and kitchen services are outsourced. Activities staff are rostered seven days a week for both the rest home and the hospital level residents.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and</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 material containing sensitive resident information. Entries in records are legible, dated and signed by the relevant HCA or registered nurse. Individual resident files</p>

accessible when required.		demonstrate service integration. This includes medical care interventions and records of the activities coordinators.
<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>All residents are assessed prior to entry. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the Code of rights, advocacy and complaints procedure.</p> <p>There is a comprehensive admission booklet available to all residents/family/whānau on enquiry or admission. The information includes examples of how services can be accessed that are not included in the agreement. Relatives agreed that the service was proactive with providing information.</p> <p>Registered nurses interviewed were able to describe the entry and admission process. The GP is notified of a new admission.</p> <p>Signed admission agreements were sighted. The admission agreement form in use aligns with the requirements of the contracts. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</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. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</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>	PA Low	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in secure cupboards and medication trolleys. Not all eyedrops in use evidenced opening dates. Medication administration practice complies with the medication management policy for the medication rounds sighted. Medication prescribed is signed as administered on the signing chart. Registered nurses and senior healthcare assistants administer medicines. All staff that administer medication are competent and have received medication management training. The facility uses a robotic pack medication-management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medical practitioners write medication charts correctly and there was evidence of three monthly reviews by the GP. Two residents self-administer medicines from a locked draw in their rooms and both have a current competency assessment. There are no vaccines</p>

		stored on site and controlled medications are checked weekly.
<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>Food services are contracted to a food service company. There is a fully functional kitchen and all food is cooked on site by contracted kitchen staff. There is a food-services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and is provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RNs on duty. There is a registered food control plan last verified July 2018. The kitchen staff have completed food safety training. The kitchen manager and cooks follow a rotating seasonal menu, which has been reviewed recently by a dietitian. 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 very 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 immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>There is an admission information policy. The service records the reason (no bed availability or unable to meet the acuity/level of care) for declining service entry to potential residents and communicates this to potential residents/family/whānau. Potential residents would be referred back to the referring agency if entry is declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission.</p> <p>The interRAI assessment tool has been used, but not within the required timeframes for all residents (link 1.3.3.3). InterRAI assessments reviewed linked to the long-term care plans reviewed. Additional paper-based risk assessment tools are completed on admission. Risk assessments reviewed were evaluated six monthly or when there was a change in the residents' health condition. The respite file had a short stay assessment completed. Behaviour assessments are completed as required.</p> <p>Pain assessments were evidenced as completed with ongoing monitoring recorded, for residents requiring administration of controlled medication as part of prescribed pain management plan.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Residents and their family/whānau are involved in the care planning and review process. Short-term care plans were utilised for changes in health status, were evaluated on a regular basis and signed-off as resolved or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialist care professionals. Not all care plans reviewed had interventions documented to address all assessed needs. One respite resident file reviewed included an initial assessment and a short-term care plan, however the plan did not include interventions for all assessed needs. The younger person's care plan identified specific goals around activities and community involvement. Resident-centred goals were reviewed at the multi-disciplinary review (MDR) meetings with the residents. Staff interviewed reported they found the plans easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Registered nurses (RNs) and healthcare assistants follow the care plan and report progress against the care plan each shift. If external nursing or allied health advice is required the RNs will initiate a referral (e.g., to the district nurse). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Interviews with registered nurses, clinical coordinator and healthcare assistants demonstrated an understanding of the individualised needs of residents. Food and fluid charts are completed as required, however not all interventions were documented around current implemented care (link 1.3.5.2). There was evidence of pressure injury prevention interventions such as turning charts, food and fluid charts, regular monitoring of bowels and weight management.</p> <p>Wound assessment, monitoring and wound management plans are in place for 44 wounds including 33 skin tears, four skin conditions, two surgical wounds and five pressure injuries (two grade-two and three grade-one. All PI's are facility acquired). All wounds have been reviewed in appropriate timeframes and all documentation has been fully completed.</p> <p>The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>Staff interviewed stated they had training on pressure injury prevention. Sufficient pressure reducing mattresses, air mattresses and roho cushions are available. Residents on regular position changes are monitored. A specific pressure injury review is completed for all residents with pressure injuries.</p>
<p>Standard 1.3.7: Planned</p>	<p>FA</p>	<p>Lansdowne home and hospital employs three activities coordinators (two full-time and one part-time).</p>

<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>Activities are across 7 days. One activity coordinator is undertaking the DT training.</p> <p>The programme includes residents being involved in the community with social clubs, churches and schools and kindergarten. On or soon after admission, a social history is taken and information from this is added into the activities plan as part of the care plan developed by the RN's. Reviews are conducted six monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered.</p> <p>Residents are free to choose whether to participate in the group activities programme or their individual plan and participation is monitored.</p> <p>Residents and families interviewed commented positively on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans had been evaluated six monthly for five of the ten resident files reviewed. Four residents had not been at the service six months and one was a respite resident. Written evaluations identified if the desired goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. On-going nursing evaluations occur as indicated and are documented within the progress notes. 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.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the residents' files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents' files.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from</p>	FA	<p>The infection control manual contains documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. The health and safety manual include a policy around safe storage and handling of chemicals. Waste is appropriately managed.</p> <p>Chemicals are secured in designated locked cupboards. Chemicals are labelled, and safety datasheets were available in the laundry and sluice areas. Safe chemical-handling training has been provided (link</p>

<p>harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>1.2.7.5). Personal protective equipment is available, and staff were observed wearing protective clothing while carrying out their duties.</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 service displays a current building warrant of fitness, which expires on 4 March 2019. A preventative building maintenance programme ensures that all legislation is complied with. A maintenance-work notification book is available for staff to communicate with maintenance staff, of any issues and areas that require attention. Hot water temperatures are monitored and recorded monthly. The environment and buildings are well maintained. The maintenance person is available afterhours, if required. Electrical equipment is tested and tagged. All medical equipment has been calibrated and checked. The facility van is registered and has a current warrant of fitness.</p> <p>Corridors within each wing are of sufficient size to allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment. Safety rails are appropriately located.</p> <p>Lansdowne provides sufficient equipment to meet the needs of the residents including, (but not limited to); standing and sling hoists, roll on scales, sensor mats, syringe drivers, slide sheets, high low beds shower chairs and wheelchairs.</p> <p>There are outside courtyard areas with seating, tables and shaded areas that are easily accessible. Pathways, seating and grounds appear well maintained. All hazards have been identified in the hazard register.</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>	<p>FA</p>	<p>There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Several bedrooms have their own ensembles. Toilets and showers have privacy systems in place. 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</p>	<p>FA</p>	<p>All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</p>

adequate personal space/bed areas appropriate to the consumer group and setting.		
<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	Communal areas include the main lounge, several smaller lounges and four separate dining areas. The communal areas are easily and safely accessible for residents.
<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>Contracted cleaning staff clean the facility. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All laundry is done off site except kitchen personal items. Residents and relatives interviewed advised that they were satisfied with the laundry 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>A fire evacuation plan is in place that has been approved by the New Zealand 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. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back up power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</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>	<p>FA</p>	<p>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>
<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>	<p>FA</p>	<p>CHT Lansdowne has an established 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. A registered nurse is the designated infection control coordinator with support from the unit manager, the clinical coordinator and all staff as part of the quality management committee (infection control team). Minutes are available for staff. Spot 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>
<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>A registered nurse at CHT Lansdowne 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 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>
<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</p>	<p>FA</p>	<p>There are CHT infection control policies and procedures appropriate to 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. Policies have been reviewed and updated.</p>

the organisation. These policies and procedures are practical, safe, and appropriate/suitable for 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	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 (link 1.2.7.5). The infection control coordinator has completed external 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.
<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	Infection surveillance is an integral part of the infection control programme and is described in CHT's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the unit manager. There has been one respiratory outbreak since the previous audit. The outbreak was monitored, a log of infected residents and staff maintained. The GP was kept informed throughout and. Public Health was notified.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There was one hospital level resident with restraint (bedrail) and three hospital level residents with an enabler (two seatbelts and one bedrail). Assessments, consent processes, and reviews for restraint and enabler use are the same. Monitoring is established for both the restraint and enablers but is not always completed as per the monitoring schedules (link 2.2.3.4).</p> <p>Staff interviews, and staff records reviewed evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Staff education on RMSP/enablers has been provided (link to 1.2.7.5). Restraint meetings are scheduled two-weekly.</p>
Standard 2.2.1: Restraint approval and processes	FA	An enrolled nurse is the restraint coordinator. Assessment and approval processes for restraint use include the restraint coordinator, registered nurses, resident, family/EPOA and medical practitioner.

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.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The registered nurse is responsible for completing a restraint assessment for residents who require either restraint or enabler interventions. Two files reviewed (one restraint and one enabler) demonstrated that restraint/enabler assessments were completed by registered nursing staff in partnership with the family/whānau. The resident gave written consent for the use of the enabler (lapbelt in powerchair) and the family provided written consent for the use of a restraint (bedrails).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	PA Low	Restraint minimisation policies and procedures indicate that restraint is put in place only where it is clinically indicated and justified. An assessment process is completed for all restraints and enablers. The two files reviewed (one restraint, one enabler) had completed assessment forms and care plans that reflected the use of restraint and associated risks. Monitoring forms included regular two hourly monitoring for the restraint and four hourly monitoring for the enabler. Monitoring forms did not reflect consistent evidence of being completed as scheduled. The service has a restraint and enablers register, which is updated each month. The restraint coordinator reported that she is unaware of any adverse events that have resulted from the use of a restraint.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every six months at a minimum. Evaluation timeframes are determined by policy and risk levels. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the	FA	The organisation and facility are proactive in minimising restraint while also keeping residents safe. The restraint programme is reviewed annually by the CHT head office. A restraint education and training programme is in place (link 1.2.7.5) that is regularly reviewed at head office.

monitoring and quality review of their use of restraint.		
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	Internal audits are completed by an area manager, every six months. Quality improvement data is collected and collated. Missing was evidence of communicating results to staff.	Meeting minutes (e.g., quality/health and safety meetings, RN meetings) failed to reflect evidence of quality data being communicated to staff (e.g., adverse event data, internal audit results and resident surveys).	<p>Ensure quality and risk management results (e.g., adverse event data) are communicated to staff.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is</p>	PA Low	A process for developing corrective action plans has been implemented around the six-monthly internal audits, but there was a lack of	Corrective action plans that were initiated (e.g., six monthly internal audit findings) failed to indicate evidence of evaluation with sign-off.	Ensure that documentation supports evidence of corrective

developed and implemented.		documented evidence to reflect their implementation and sign-off.		actions being implemented and signed off. 90 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>A system is in place to provide ongoing education for the staff. Two in-services in 2018 were offered two times (incident/accident reporting and managing challenging behaviours) and the remaining in-services were provided one time only. Attendance rates were below 50% for a selection of mandatory in-services. Staff interviews confirmed that it can be difficult to attend the in-services with a range of reasons given. Plans are in place to increase uptake by offering online training with one online programme offered at the time of the audit (food safety).</p>	<p>Attendance at in-service training over the past two years reflects very low attendance rates (less than 50%) at a selection of mandatory training (e.g., restraint minimisation, elder abuse and code of rights, accidents/incident reporting, cultural safety, health and safety/hazard identification).</p>	<p>Ensure staff meet all CHT mandatory training requirements.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	<p>All medications are stored securely according to the policy and procedure. Six of eight eyedrops in use had opening dates documented on the bottle.</p>	<p>Two eyedrops in current use did not have an opening date documented on the container.</p>	<p>Ensure all eyedrops include document an opening date.</p> <p>90 days</p>

<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>Ten files were reviewed including seven hospital residents and three rest home residents. Seven of these residents had been admitted in the last two years.</p>	<p>(i) One of seven hospital residents did not have an initial assessment and care plan completed within 48 hours of admission.</p> <p>(ii) Two of seven hospital residents did not have an interRAI completed within 21 days of admission.</p> <p>(iii) Four of seven hospital residents did not have a long-term care plan completed within 21 days of admission.</p> <p>(iv) Subsequent interRAIs were not completed within the six-month timeframe for one hospital resident.</p>	<p>(i) Ensure all new residents have admission assessment and care plans completed within 48 hours.</p> <p>(ii) Ensure all residents admitted on an ARCC long-term contract have an interRAI assessment completed within 21 days of admission.</p> <p>(iii) Ensure all permanent residents have a long-term care plan completed within 21 days.</p> <p>(iv) Ensure all permanent residents have an interRAI assessment completed six monthly.</p>
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				90 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>	<p>PA Moderate</p>	<p>The registered nurse is responsible for completing all necessary assessments and then using this information to document the care plan. Nurses undertake a risk assessment for all residents; however, interventions were not documented for all assessed care needs. Three of ten care plans described the support and interventions required to meet all the resident's goals and assessed needs.</p>	<p>Interventions had not been fully documented to address the following assessed needs and risks; (i) One respite rest home resident with an indwelling catheter, minimal English and on regular food supplements; (ii) One recent hospital admission assessed as a high falls risk and at high risk of pressure injury; (iii) One hospital resident with mood changes and urinary incontinence; (iv) One rest home resident on warfarin medication and on food and fluid monitoring (noting this was being completed by staff); (v) Two hospital residents with diabetes requiring insulin; (vi) three hospital residents with cognitive impairment, and (vii) cultural needs for one hospital (YPD) resident.</p>	<p>Ensure care plans fully document all interventions to address all assessed needs.</p> <p>60 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p>	<p>PA Low</p>	<p>Monitoring forms were sighted for both residents (one restraint and one enabler). There were gaps in the monitoring charts that indicated residents were not checked as per their monitoring schedules.</p>	<p>Monitoring forms reviewed did not reflect consistent evidence of two hourly monitoring of the restraint and four hourly monitoring of the enabler.</p>	<p>Ensure that monitoring forms indicate residents are checked as per the monitoring schedules.</p> <p>90 days</p>

(d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.				
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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.