

CHT Healthcare Trust - St Christophers Rest Home & 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:	St Christophers Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 October 2018 End date: 2 October 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:	45

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

CHT St Christophers is owned and operated by the CHT Healthcare Trust. The service cares for up to 46 residents requiring hospital and rest home level care. On the day of the audit, there were 45 residents. The clinical coordinator is currently in the role of acting unit manager and is overseeing the service with the support of the area manager. She is supported by a registered nurse who has been at St Christophers for one year and is currently working as the acting clinical coordinator. Residents, relatives and the GP interviewed spoke positively about the service 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 a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff and management.

This audit has identified areas for improvement around internal auditing and care planning.

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.
--	--	--

CHT St Christophers strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is easily accessible to residents and families. Policies are implemented to support residents' rights. Informed consent processes are followed, and residents' clinical files reviewed, evidence informed consent is obtained. Staff interviews inform a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are promptly managed.

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.
---	--	---

The quality and risk management programme includes service philosophy, goals and a quality planner. The CHT management team provide support and direction to the unit manager. Quality activities are completed, and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents/family meetings have been held regularly. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. An education and training programme has been implemented with a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Resident information is appropriately stored and managed.

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>
---	--	---

There is a welcome pack that contains information on the services and levels of care available at CHT St Christophers. Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. The care plans are resident and goal orientated, and evaluated 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 seven-day activity programme in the rest home/hospital 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 on site by a contracted service. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

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.
--	--	--

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. There are two double rooms and the remainder are single. There is a mix of communal toilet/showers and ensuites. Each unit has a 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. Laundry is completed off-site. 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.

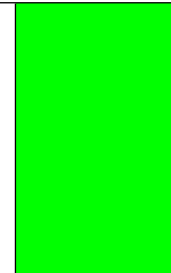
Restraint minimisation and safe practice

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.
---	--	--

CHT St Christophers has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were two residents with restraint and four residents with enablers. Restraint management processes are adhered to.

Infection prevention and control

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



Standards applicable to this service fully attained.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	48	0	1	1	0	0
Criteria	0	99	0	1	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 Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (three healthcare assistants, two registered nurses (RN), one activities coordinator, one food services manager, one chef, one maintenance officer, one clinical coordinator and one-unit manager) confirm their familiarity with the Code. Interviews with four residents (three hospital and one rest home) and four families (three hospital and one rest home) confirm the services being provided are in line with the Code. Observation during the audit confirmed this is in practice. Staff have received training on the Code of Health and Disability Services, Code of Rights and Employee Code of Conduct. All staff files sampled include a signed copy of the Code of Conduct.</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. Seven resident files reviewed (five hospital including one younger resident with a chronic health condition and two rest home residents including one on respite care) demonstrated that consents had been signed. Resuscitation forms sighted 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'. The resuscitation form includes an advance directive for CPR if the resident condition deteriorates. Copies of enduring power of attorney (EPOA) where available were sighted in the resident file.</p>

consent.		Three healthcare assistants (HCAs) and three 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 for respite care had a short-stay agreement.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff, residents and relatives informed they were aware of advocacy and how to access an advocate.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of complaints process. There are complaint forms available throughout the facility. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a complaints register.</p> <p>There were eleven complaints for 2017 and four complaints (including one made via the DHB which has also gone to Health and Disability) made in 2018, year to date. All complaints reviewed had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. Discussions with residents confirmed that any issues are addressed, and they feel comfortable to raise any concerns.</p> <p>The service has responded to the DHB complaint and implemented corrective actions including (but not limited to) staff training, performance monitoring and resident and family meetings. A MOH issues-based audit was conducted in September 2018 with no identified shortfalls found. The Ministry requested follow up against aspects of the complaint at this certification audit that included; (i) consumer rights during service delivery, (ii) independence, personal privacy and respect; (iii) complaints management; (iv)</p>

		evidence demonstrating resident and family feedback and actions taken, and (v) attendance and training of staff related to consumer rights, complaints management and quality and risk management. There were no identified issues in respect of this complaint.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There are posters of the code of rights on display throughout the facility and leaflets are available in the foyer. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the unit manager discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code of Rights.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage to maintain privacy and respect of personal property. All residents interviewed stated their needs were met. A policy describes spiritual care. Church services occur regularly. All residents interviewed indicated that resident's spiritual needs are being met when required.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	There are current policies and procedures for the provision of culturally safe care for Māori residents including a Māori health plan, Tikanga best practice guidelines, cultural protocols and consultation with Māori representatives. St Christophers has an established relationship with Te Oranga Kaumātua Kuia Disability Support Services Trust. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually. One resident identified as Māori on the day of the audit. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process. Discussions with staff confirm that they are aware of the need to respond to cultural differences.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally	FA	The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including residents' cultural beliefs and values, is used to develop a care plan. Staff receive training on cultural awareness.

safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	St Christophers has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination free environment. The Code of Rights is included in orientation and in-service training. Training is provided as part of the staff training and education plan. Interviews with staff confirm their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identify that privacy is ensured.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies to guide practice that aligns with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Staffing policies include the requirement to attend orientation and ongoing in-service training.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy around open disclosure alerts staff to their responsibility to notify family/next of kin of any accidents/incidents that occur. Sixteen incidents/accidents forms were reviewed for August and September 2018. The forms included a section to record family notification. All forms indicated family were informed or if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	CHT St Christophers rest home and hospital is owned and operated by the CHT Healthcare Trust. The service provides rest home and hospital (medical and geriatric) level care for up to 46 residents. CHT also holds contracts for primary option acute care, young persons with disabilities and long term chronic conditions. On the day of the audit, there were 45 residents in total, five rest home level (including one respite resident) and 40 hospital level (including one resident on LTS-CHC). All other residents were on the aged-related care contract. All beds are dual-purpose.

		<p>The acting unit manager is a registered nurse and maintains an annual practicing certificate. She has been in the acting unit manager role at the facility for one month and prior to that had been the clinical coordinator for one year. An acting clinical coordinator who has been in the position for one month has worked at St Christopher's for over a year as a RN and supports the unit manager. The unit manager reports to the area manager weekly on a variety of operational issues. The Ministry of Health has been notified of the temporary change of facility manager. CHT has an overall business/strategic plan and CHT St Christophers rest home and hospital has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement.</p> <p>The acting unit manager has completed in excess of eight hours of professional development in the past 12 months.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the absence of the unit manager, the clinical coordinator is in charge, with support from the area manager, the registered nurses and healthcare assistants.</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>	PA Low	<p>There is an organisational business/strategic plan that includes quality goals and risk management plans. The acting unit manager advised that she is responsible for providing oversight of the quality programme. The quality and risk management programme is designed to monitor contractual and standards compliance. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff, as evidenced in meeting minutes. Staff have access to manuals. Interviews with staff confirmed that quality data including complaints is discussed at monthly staff meetings to which all staff are invited. Resident/relative meetings are held bi-monthly and include feedback and discussion on complaints management. Residents and families are encouraged to raise concerns and are reminded of available options to lodge complaints. Restraint and enabler use is reported within the clinical and staff meetings.</p> <p>Data is collected in relation to a variety of quality activities and six-monthly internal audits are routinely scheduled, however not all scheduled audits have been completed as scheduled. Areas of non-compliance identified through quality activities are actioned for improvement. A sample of residents are also surveyed every month regarding their level of satisfaction with the service, but data is not being</p>

		<p>collated for analysis purposes. Instead, surveys are reviewed individually. Adverse comments from the surveys are added to the complaints register and actioned appropriately. Residents and families are informed of comments and actions via regular meetings and newsletters</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>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The unit manager investigates accidents and near misses and analysis of incident trends occur. There is a discussion of incidents/accidents at monthly clinical and staff meetings including actions to minimise recurrence. Staff interviewed confirms incident and accident data are discussed and information and graphs are made available.</p> <p>Incident and accident data is collected and analysed and benchmarked through the CHT internal benchmarking programme. A sample of resident related incident reports for August and September 2018 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care was provided following an incident. Neurological observations were completed for all unwitnessed falls. Documentation including care plan interventions for prevention of incidents, was fully documented. Incident reports were fully completed, and family notified of all incidents sampled.</p> <p>Discussions with management confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one death referred to the coroners. There was appropriate notification made around a skin infection outbreak.</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</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices including relevant checks to validate the individual's qualifications, experience and veracity. Six staff files (three healthcare assistants, two RN's and acting unit manager) sampled contained all relevant employment documentation. Current practising certificates were sighted for the RN's, and allied health professionals. All staff sign a code of conduct and code of confidentiality. Performance appraisals were up to date. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment.</p> <p>The education planner in place covers the compulsory education requirements as well as additional clinical</p>

legislation.		in-service and external education. Seven of the eight RN's have completed interRAI training. The in-service education programme for 2017 has been completed and a plan for 2018 is being implemented. Staff attendance at in-service training is closely monitored and all staff attend compulsory sessions. With 25 HCA and eight RN's staff attendance has been sitting over 80% for compulsory sessions across the last two years. Recent training includes (but is not limited to) Code of Rights, accident and incident reporting and management, abuse and neglect, moving and handling, complaints and advocacy, pressure injury prevention programme and privacy and dignity. The unit manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Staff complete competencies relevant to their role including medication, hand hygiene and safe manual handling.
<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>	FA	<p>CHT organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The acting unit manager and clinical coordinator work full-time Monday to Friday and are on call 24/7. They are supported by an area manager and registered nurses. Interviews with three healthcare assistants stated the RNs are supportive and approachable. In addition, they reported there are sufficient staff on duty at all times. Interviews with residents and relatives indicated they were overall happy there were sufficient staff to meet resident needs. The registered nurse on each shift is aware that extra staff can be called on for increased resident requirements.</p> <p>Staffing at CHT St Christophers is as follows; The service is divided into four wings known as Kauri, Rimu, Nikau and Puriri. All rooms are dual-purpose, although rest home residents are cared for mainly in the ten-bed Nikau and Puriri wings.</p> <p>The rest home wings Puriri and Nikau (5 rest home, 15 hospital) are rostered as one and an RN is rostered from 8am - 12pm Monday to Friday with a 7am – 3pm RN rostered in the weekends. Morning shift is covered by three HCA's (two long shifts and one short). On the afternoon shift, there are two long shifts and one full shift on night shift.</p> <p>There are twelve in Kauri and thirteen in Rimu hospital residents in each of Kauri and Rimu wings (25 hospital residents in total) and an RN is rostered across both areas in the morning shift. One RN is rostered across the facility for the afternoon and night shift. There are two HCA's (both long shifts) on each wing on the morning shift. In the afternoon, there are two full shift HCA's in Rimu wing and one long and one short in Kauri. There is one HCA in each wing on night shift.</p> <p>There are also two activities coordinators (9.30am- 3pm), one in the hospital wings and one in the rest home wings. The clinical manager is based in the rest home.</p>
Standard 1.2.9: Consumer	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial

<p>Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The service has admission policies and processes in place. Residents receive an information pack outlining the services able to be provided. The acting unit manager/registered nurse 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 acting 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>	<p>FA</p>	<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>	<p>FA</p>	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are stored safely in the rest home and hospital units. Registered nurses and senior HCAs are responsible for medication administration and complete annual medication competencies and annual medication education provided by the pharmacy. Registered nurses have completed syringe driver competencies through the hospice. Robotic medication rolls are checked on delivery by the RN on duty and date entered into the electronic medication system. There is an impress stock and bulk supply order (for hospital level residents) which is checked regularly for expiry dates. Eyedrops in both medication trolleys were dated on opening. The medication fridges are checked daily and temperatures were within acceptable ranges. There are no vaccines stored on-site. There were no residents self-medicating on the day of audit.</p> <p>The service uses an electronic medication system. Fourteen medication charts on the electronic medication system were reviewed. All charts met prescribing requirements including the indication for use</p>

		of as required medications. The effectiveness of as required medications had been entered into the electronic system. All charts had photo identification and allergy status identified.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals and baking are done on-site 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 verified and expires August 2019. Staff have completed food safety training in August 2018. The chef manager on duty is supported by catering assistants. The four-weekly seasonal menus have been reviewed by the contracted dietitian. The main meal is at midday with a lighter meal in the evening. The menu provides vegetarian options, soft/pureed options. Dietary requirements around ethnicities and religious needs are supported. Dislikes and food allergies are known and accommodated. The service uses the international colour coding to identify special diets and allergies. Fortified foods (REAP) is provided for residents with identified weight loss and as instructed by the RN/dietitian. The kitchen is adjacent to the rest home dining room and meals are served from the bain marie in the kitchen to residents in the dining room. Meals are plated in the kitchen for the hospital dining room and delivered in a scan box. There is specialised crockery and cutlery for use as required.</p> <p>The temperatures of refrigerators, chillers, 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. Residents interviewed commented positively on the meals.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the 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 Consumers' needs, support requirements, and preferences are gathered and</p>	FA	<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</p>

<p>recorded in a timely manner.</p>		<p>long-term residents and care plans were developed based on these assessments. Additional assessments were completed as required such as wound assessments. An admission assessment had been completed for the respite care resident.</p> <p>The activity coordinator completes an activity assessment on admission for all residents, including younger person (LTS-CHC) which identifies their individual interests, hobbies and links with the community.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Long-term care plans for permanent residents had been completed within three weeks on VCare. In four of seven resident files reviewed, the long-term care plans reflected the resident's current needs/supports to achieve the resident goals. The resident under respite care has a short-term care plan in place. The InterRAI assessment process informs the development of the resident's care plan for long-term residents. Residents and their family/whānau interviewed reported that they are involved in the care planning process. The care plan for younger person under a LTS-CHC, reflected individual choice including daily activities of living and interests and hobbies.</p> <p>Short-term care plans are in use for short term needs including infections, weight loss and wounds. 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, specialist wound care nurse, community geriatric nurse and the mental health team.</p>
<p>Standard 1.3.6: Service Delivery/Interventions 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 (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 residents with current wounds including one facility-acquired stage two pressure injury. There is sufficient pressure relieving equipment such as cushions and air alternating mattresses. Documentation and photos monitor healing progress. The wound nurse specialist can be accessed if required.</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 change of position charts, food and fluid charts, regular monitoring of bowels, monthly weights, blood pressure, blood sugar levels, pain</p>

		monitoring and behaviour, as required.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs two activity coordinators. One activity coordinator (level three Careerforce) works Monday to Friday and the second activity coordinator works the weekends. The seven-day programme is integrated and from 9.30am to 3pm daily. Activities rotate between the rest home and hospital lounges. Residents receive a copy of the weekly programme. Activities include (but not limited to); newspaper reading, a variety of exercises (sit-dancing, balloon tennis), board games, roller cricket, sensory activities, movie and ice-cream, happy hours, walks, crafts, bowls and hand and nail care. There are weekly exercises with the physiotherapist. One-on-one individual time is spent with residents who do not wish or are unable to participate in group activities.</p> <p>The service contracts a mobility bus for its hospital/rest home residents. There are weekly outings (one in the morning and one in the afternoon) to the plaza for shopping and morning tea and scenic drives. Community visitors to the facility include musical entertainers, choirs, Chinese Baptist singing group, Chinese Society, weekly church services, pre-schoolers and school children and pet therapy visits.</p> <p>The younger person under LTS-CHC chooses to attend activities of interest. There is an individualised activity plan that includes one on one time for chats and being supported to do personal shopping. The resident enjoys the outings.</p> <p>A lifestyle questionnaire is completed soon after a resident's admission. There is a life map in each resident room that helps prompt discussion. An individual activities plan is developed for each resident and included in the VCare plan which is evaluated six-monthly in consultation with the resident and RN. Residents have the opportunity to feedback on the activity programme through resident meetings and surveys. Residents and relatives interviewed stated they were happy 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>	FA	<p>Initial care plans reviewed had been evaluated by the registered nurses within three weeks of admission. The long-term care plans are reviewed three-monthly by the RNs and evaluated at least six-monthly or earlier for health changes in four of six long-term files reviewed. Two residents (one hospital and one rest home) had not been at the service six months. One resident was respite care. The short-term respite resident was not required to have an evaluation. There are six-monthly care plan evaluations involving care staff, applicable allied health professionals and the resident/relative. 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 and updated with any changes to care (link 1.3.5.2)</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>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. 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>	FA	<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 and chemicals are pre-mixed through a dispensing system. Safety data sheets and product sheets are readily available in the two sluice rooms and cleaners' room.</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>	FA	<p>The building has a current building warrant of fitness that expires 16 March 2019. The maintenance person covers four sites and on-site one day a week. The on-call is shared with the building manager. Staff log any items for maintenance and repair into a maintenance book at reception. The maintenance book viewed demonstrates maintenance and repairs are addressed within a timely manner. Any urgent concerns can be emailed or phoned to the maintenance person. A computerized system is used for maintenance records and for reporting to the building manager. There are contractors available 24 hours for essential services.</p> <p>There is a planned maintenance schedule in place for internal and external building maintenance. Monthly hot water temperature checks are completed and are below 45 degrees Celsius. Equipment has been tested and tagged and clinical equipment calibrated. There are monthly call bell audits.</p> <p>The facility has sufficient space and wide corridors for residents to mobilise using mobility aids. External areas are well maintained. Residents have safe access to external areas that have seating and shade. A groundsman is employed to maintain the gardens and grounds for all local sites.</p>

		Care staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.
<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	Resident rooms in the rest home unit all have hand basins. The toilet/shower facilities are communal and have privacy locks and call bells. One double room in the rest home has an ensuite. All resident rooms in the hospital unit have ensuites. There is a large communal bathroom in the facility for the use of a shower trolley if required. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.
<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	There are two double rooms in the rest home unit. Privacy curtains are in place if required. All other resident rooms in the facility are single rooms. All resident rooms are for rest home or hospital level of care and 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. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<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	<p>There are two units each with a large lounge for activities. There are two wings per unit. The hospital lounge is part of an open plan dining/lounge area. There is a separate dining room in the rest home unit. There is a smaller lounge that can be used for visitor/family time and quieter activities.</p> <p>Seating and space can be arranged to allow both individual and group activities to occur. There are outdoor garden areas with seating and shade and raised garden beds.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with</p>	FA	The cleaning and laundry services are a contracted service. Cleaners have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Cleaning trolleys are stored in a locked cupboard when not in use. Safety

<p>safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>data sheets and product sheets are available. Cleaners have completed chemical safety training.</p> <p>All personal laundry and linen are completed in an external commercial laundry at one of the other CHT sites. There are defined clean/dirty areas for the pickup and collection of laundry within the facility. A specialised van is used for the deliveries and pickups (viewed). There was sufficient clean laundry viewed on-site. Residents interviewed were satisfied with the standard of cleanliness in the facility and 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>	<p>FA</p>	<p>The fire evacuation plan has been approved by the fire service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted. Fire training and security situations are part of orientation of new staff and include competency assessments. There are adequate supplies in the event of a civil defence emergency including food, water and gas cooking. Short-term back up power for emergency lighting and the call bell system is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available 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. The building is secure after hours.</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>All rooms have external windows that open, allowing plenty of natural sunlight. There is plenty of natural light in the communal areas. Doors in the rest home dining room open out onto the gardens and the lounge doors in the hospital also open out onto the gardens. Residents and relatives reported the temperature was comfortable.</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,</p>	<p>FA</p>	<p>St Christophers rest home and hospital has an infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator with support from the unit manager, the clinical coordinator and all staff as the quality management committee (infection control team). Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff</p>

and visitors. This shall be appropriate to the size and scope of the service.		on orientation. The infection control programme has been reviewed annually.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	A registered nurse at St Christophers 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) have 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. Handwashing facilities are available throughout the facility and alcohol handgel is freely available.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	There are CHT infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.
<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. The infection control coordinator has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection control coordinator/RN oversees infection surveillance for the service. Surveillance is an integral part of the infection control programme and is described in CHTs infection control manual. Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends and analysis of infection events, outcomes and actions are discussed at the combined quality/health and safety and infection control meetings. Results from laboratory tests are available monthly. There have been two unconfirmed skin condition outbreaks. The outbreaks were managed appropriately, and notifications 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>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were two residents with restraint and four residents with an enabler. All restraints and three enablers are bedrails. One enabler is a lapbelt. One enabler file sampled documented that enabler use was voluntary. All necessary documentation has been completed in relation to the restraints. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff training/education on restraint/enablers has recently been provided in May 2016. Restraint is discussed as part of staff meetings. A registered nurse is the designated restraint coordinator.</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 restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>A registered nurse is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated,</p>	<p>FA</p>	<p>The service completes comprehensive assessments for residents who require restraint or enabler interventions. Two restraints and one enabler resident files were reviewed. Assessments completed in these files were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved</p>

in relation to use of restraint.		in the assessment and consent process. In the files reviewed, assessments and consents were fully completed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified, and approval processes are obtained/met. An assessment form is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular monitoring at the frequency determined by the risk level were present in the files reviewed. The service has a restraint and enablers register, which is updated each month.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every six months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. Evaluation timeframes are determined by policy and risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. The restraint coordinator and unit manager complete the restraint review. Any adverse outcomes are reported at the monthly combined, health and safety and infection control meetings.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Low	Internal audits are planned six-monthly and follow a template approved at head office. There are separate internal audit tools for restraint, human resources and infection control, however not all internal audits have been fully utilised as planned.	i) Internal audits have not occurred at the frequency identified in their quality plan. ii) Internal audits have not included HR, IC and restraint over the last two years.	Ensure the internal audit programme is completed as planned and cover all service components. 90 days
Criterion 1.3.5.2 Service delivery	PA Moderate	In four of seven care plans, interventions described the	a) There are no documented interventions for the respite resident around managing and identifying signs and symptoms of congestive	Ensure interventions

<p>plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>current supports required to meet the resident's goals needs. Three care plans did not include all interventions to support the current health status.</p>	<p>heart failure and increasing pain. The care plan did not reflect updated interventions to support the change in condition, b) the use of a wandtrak for one hospital resident has not been identified in the care plan, and c) another hospital resident care plan did not reflect monitoring requirements for fluid restriction. The interventions to support care for breathlessness had not been updated in the care plan as per GP notes.</p>	<p>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, 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.