

CHT Healthcare Trust - St Johns

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 Johns Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
Dates of audit:	Start date: 10 September 2019 End date: 11 September 2019

Proposed changes to current services (if any): The table above states the service provides rest home level care. The service is only certified for rest home-dementia level care, not rest home level care.

Total beds occupied across all premises included in the audit on the first day of the audit: 86



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 St Johns is owned and operated by the CHT Healthcare Trust. The service cares for up to 90 residents across three service levels (hospital, residential disability and dementia level care). On the day of the audit, there were 86 residents. The unit manager oversees the service with the support of the area manager and 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 and the general practitioner.

This audit has identified an area for improvement around neurological observations.

The service has been awarded continuous improvement ratings for good practice, falls reduction and restraint minimisation.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

All standards applicable to this service fully attained with some standards exceeded.

CHT St Johns 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 evidenced informed consent is obtained. Staff interviews informed 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.

Standards applicable to this service fully attained.

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 conducted, and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Resident/family meetings have been held six monthly. 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 have been implemented with an online and on-site training plan. 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

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

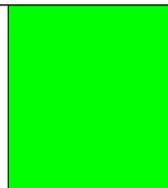
Medication policies reflect legislative requirements and guidelines. Registered nurses and senior medication competent healthcare assistants are responsible for the administration of medicines in the hospital and the dementia unit. Medication charts are reviewed three monthly by the GP.

The activities coordinators implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals. Snacks are available at all times.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

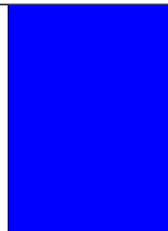


Standards applicable to this service fully attained.

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. All rooms are single, and all have ensuites. External areas are safe and well maintained with shade and seating available. There is an enclosed garden for the two dementia suites. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services. There is a first aider on duty 24 hours.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



All standards applicable to this service fully attained with some standards exceeded.

CHT St Johns has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. The service uses restraint as a last resort. On the day of audit, there was one resident with restraint and two 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.

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 responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There was an outbreak in 2018.

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	2	47	0	0	1	0	0
Criteria	3	97	0	0	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 (thirteen healthcare assistants, three registered nurses (RN) and three activities coordinators) confirmed their familiarity with the Code. Interviews with eight hospital level of care residents (including one YPD) and three family members (of two dementia level of care and one hospital level of care) confirmed the services being provided are in line with the Code. Observation during the audit confirmed this 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 reviewed included 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</p>	FA	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on all resident files reviewed (eight hospital and two dementia). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence was filed in the residents' charts. Both dementia files reviewed had activated EPOAs.</p>

give informed consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance to the facility. 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. Interviews with staff, residents and relatives informed they were aware of advocacy and how to access an advocate. An HDC advocate has attended the resident/relative meeting.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are encouraged to be involved in community activities and maintain family and 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. There are visiting school children and spiritual support workers.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are in an accessible and visible location. Information about the complaints process is provided on admission. Managers (one area manager and one-unit manager) and 13 care staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaints' register is maintained. Verbal and written complaints are documented and include any concerns identified in the resident/relative meetings and satisfaction surveys. Fifteen complaints have been lodged in 2019 (year-to-date). All complaints had a documented investigation and the outcome communicated to the complainant by letter or face-to-face meetings. Timeframes for addressing each complaint were compliant with the Health and Disability Commissioner (HDC) guidelines and corrective actions (when required) were documented.</p> <p>One complaint that had been lodged with HDC July 2017 and was closed off April 2019. The Ministry requested follow up against aspects of the complaint that included timeliness of service provision in regard to wound/skin care, specialist referrals, notification of next of kin, assessments and short-term care plans and review of care plans. Recommendations have been implemented and there were no identified issues in respect of this complaint.</p> <p>Complaints received and corrective actions are discussed in the quarterly quality meetings. Interviews with residents and relatives confirmed that they feel comfortable in bringing up concerns with the RNs and management</p>

		team.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	There are posters of the code of rights on display throughout the facility and leaflets are available in the main entrance/reception. 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 and advocacy information.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	The service 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 and staff were very respectful and maintained their dignity at all times. Staff receive training around privacy and dignity and elder abuse and neglect.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	There are 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 Johns has an established relationship with Te Puna Auckland university and a local primary and secondary school for advice and support when required. There were no residents who identified with Māori on the day of audit. Discussions with staff confirmed that they are aware of the need to respond to cultural differences.
Standard 1.1.6:	FA	The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents

<p>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>		<p>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 and diversity and could describe how they communicate with residents of another culture. A policy describes spiritual care. Church services occur regularly. There are volunteers who provide spiritual visits for (all denominations) on a regular basis. All residents interviewed indicated that their spiritual needs were being met when required and evaluated as part of the care plan review.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>St Johns 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 confirmed their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identified that they are treated fairly without any discrimination.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>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. The service reviews quality data to identify any areas for improvement and have quality initiatives in place and have participated in the SHARE programme with Auckland University School of Nursing.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Residents interviewed (as appropriate) and family members stated they were welcomed on entry and given time and explanation about the services and procedures. Thirteen accident/incidents reviewed identified the relative had been notified. This was confirmed on interview with family members. Six monthly resident/relative meetings are held, and speakers attend to feedback/discuss services such as the dietitian, food service manager and laundry manager. Family newsletters are published quarterly. There are portable phones, skype available on laptops and Wi-Fi to encourage families and residents to maintain communication. There is access to interpreters as required. A volunteer visits monthly to maintain contact and provide support as required for Chinese residents and those of other cultures.</p>

conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>CHT St Johns is owned and operated by the CHT Healthcare Trust. The service provides dementia care, hospital level care and younger person with physical disabilities for up to 90 residents. On the day of the audit, there were 86 residents in total. There were 20 dementia care residents, 61 hospital level residents and five younger persons at hospital level with physical disabilities. There were no residents under respite care.</p> <p>CHT has an overall business/strategic plan that includes the values and vision of the organisation: compassion, companionship, care, comfort and connected. There are area managers that report to the CEO at head office. St Johns has a unit-specific performance plan that identifies annual goals and measures such as reduction of falls, health and safety including participation in the Quality, Health and Safety Commission committee.</p> <p>The unit manager/registered nurse has been in the role at St Johns for 12 years. She is supported by an area manager (present during the audit) and a clinical coordinator. The unit manager reports to the area manager on a variety of operational issues. The area manager visits the site fortnightly.</p> <p>The unit manager has completed in excess of eight hours of professional development in the past 12 months including attending provider cluster meetings, aged care manager workshops, employment law and health and safety.</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>	FA	<p>There is a unit business/strategic plan that includes quality goals and risk management plans. The unit manager advised that she is responsible for providing oversight of the quality programme. The quality and risk management programme is designed to monitor contractual and standards compliance.</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>A document control system is in place with all quality documents reviewed on an annual basis by area managers. New policies or changes to policy are sent to the unit and communicated to staff, as evidenced in meeting minutes. Staff have access to the electronic “file vision” documents.</p> <p>Data is collected in relation to a variety of quality activities including adverse events, incidents/accidents, infections, restraint, medications, concerns/complaints and internal audit outcomes. Staff interviewed confirmed they are kept informed on quality data, trends and correctives actions at the quarterly combined quality/health and safety meetings. There are staff household meetings and staff “round up” newsletters for staff. Meeting minutes are made available to staff.</p> <p>The area manger completes six monthly internal audits against core standards, restraint and infection control. Areas of non-compliance identified through quality activities are actioned for improvement. Corrective actions have been signed off when completed.</p> <p>Annual resident/relative surveys are completed, and the results fed back to participant through newsletters and resident/relative meetings. The 2019 results for care 84% and activities 88%. There was an area identified for improvement around meals. An action plan was developed and implemented with positive comments from residents and family at audit. The service completes monthly resident surveys (sent out to resident with birthdays in the month). Action plans are developed for trends and feedback to the participant is optional.</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. Health and safety is included in the combined quality/health and safety meetings. There are two health and safety representatives. One representative (interviewed) has completed stage two health and safety representative training. All new staff complete a health and safety induction including emergency situations, fire safety and safe moving and handling. Hazard identification forms are implemented. There is a current hazard register in place. All contractors complete an induction to the facility. CHT had an independent health and safety audit conducted in 2018 and changes implemented to meet recommendations.</p> <p>Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. There has been a reduction in falls in the dementia suites.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically</p>	<p>FA</p>	<p>Incident and accident data is collected and analysed and benchmarked through the CHT internal benchmarking programme. Fifteen resident related incident reports for July were reviewed. All reports evidenced that family had been notified and appropriate clinical care was provided following an incident, however not all neurological observations were completed for all unwitnessed falls (link 1.3.6.1). Documentation including care plan interventions for prevention of incidents, was fully documented.</p> <p>There is an accidents and incidents reporting policy. The unit manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at quality/health and safety,</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>clinical meetings and handovers, including actions to minimise recurrence. Staff interviewed confirmed incident and accident data are discussed and information is made available.</p> <p>Discussions with management confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been five Section 31 notifications since the previous audit including two pressure injuries in July 2017 (one community acquired unstageable and one stage four), power outage in April 2018, scabies outbreak in April 2018 and RN staffing cover in July 2019.</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>	<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. Ten staff files (one clinical coordinator, three RNs, four healthcare assistants, one activity coordinator/health and safety representative, and one diversional therapist) reviewed, contained all relevant employment documentation and job descriptions. Current practising certificates were sighted for the RNs, and allied health professionals. All staff signed a code of conduct, code of confidentiality and information technology policy. 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 service introduced Altura on-line training in January 2019. The Altura education planner covers the compulsory education requirements. There are additional on-site clinical in-services and external education offered. Hoist training is completed by an external company. The pharmacist provides medication training. Staff individual records of training is maintained. Staff complete competencies relevant to their role including medication, hand hygiene and safe manual handling. There are three Careerforce assessors to support HCAs progress through the Careerforce units. There are 18 HCAs who work in the dementia suites. Ten HCAs have completed dementia unit standards and eight are progressing through the units to be completed within 18 months. Nine of the twelve RNs have completed interRAI training.</p> <p>Registered nurses and HCAs have the opportunity to attend gerontology nurse specialist study days at the DHB.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or</p>	<p>FA</p>	<p>CHT organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The unit manager and clinical coordinator work fulltime Monday to Friday and are on call 24/7. They are supported by an area manager and registered nurses. The service is actively recruiting for casual RNs and HCAs to cover for periods of leave/sickness. The same bureau nurses are requested to cover for RN leave. Interviews with residents and relatives indicated there are generally sufficient staff to meet resident needs. The registered nurse on each shift is aware that staff working short shifts or float shifts can be extended to meet increased resident requirements.</p> <p>The facility is divided into 11 suites. Suites 1-5 have eight beds each, suite 6 is reception/administration, suites 7,</p>

<p>experienced service providers.</p>		<p>10 and 11 (upstairs) have 10 beds and suites 8 and 9 (dementia care) have 10 beds each. Suites 1 – 9 were fully occupied. Suite 10 had nine hospital residents and suite 11 had seven hospital residents.</p> <p>There are four RNs on morning shifts that are allocated to the suites as follows: one to suite 2-5, one to suite 1,7 and 11, one to suite 10, 8 and 9. The fourth RN is on duty from 12 midday to 8.30 pm in the dementia suites.</p> <p>There are two RNs on the afternoon shift and are allocated as follows: one to suites 2-5, one to suites 1,7, 10 and 11. There is an RN on until 8.30 pm in the dementia suites.</p> <p>There is one RN on night shift to cover the suites. She is supported by four HCAs for the hospital suites and one HCA in the dementia suites.</p> <p>There is a full HCA shift in each hospital suite. For suites 1–5 (eight beds each suite) there are three float HCAs (8 am to 1 pm). There is an 8 am-1 pm HCA shift in 10 bed hospital suites 7, 10 and 11.</p> <p>There two HCAs on full shift and one short shift for suites 8 and 9 dementia units. There is an activity person from midday to 7 pm in the dementia suites.</p> <p>On the afternoon shifts there is an HCA on full shift in each hospital suite with a “float” (four hours shift) between suites 1-5 and one between suites 7, 10 and 11. There are two HCAs on full shift in the dementia suites.</p> <p>In regard to the younger people, there are two in suite 3, two in suite 7 and one in suite 11.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being locked away in the nurses’ stations. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse. Electronic records are password protected.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry which also includes the secure environment for residents with dementia. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated.</p>

<p>respectful manner, when their need for services has been identified.</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>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the 'yellow envelope' transfer system. Communication with family is made.</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>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs administer all medications in the dementia unit, but RNs and senior medication competent HCAs administer medications in the hospital. In the hospital all medications are kept in residents' locked drawers. Staff attend annual education and have an annual medication competency completed. Most RNs are syringe driver trained by the hospice. The medication fridge temperature is checked every two days. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on the electronic system. Twenty medication charts were reviewed (sixteen hospital and four dementia). Medications are reviewed at least three monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs</p>	<p>FA</p>	<p>The service uses a contracted food service, but all food is cooked on site. There is a chef manager who works 8 am to 5 pm Monday to Friday. Another cook covers weekends. There is a kitchenhand every day. They work 8 am to 1 pm and 11 am to 6 pm. All kitchen staff have current food safety certificates. The chef manager oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen. Meals are served in each area from hot boxes. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits</p>

<p>are met where this service is a component of service delivery.</p>		<p>are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted. The six weekly menu cycle is approved by a dietitian. Moulded puree diets are available. If a resident has a weight loss they are seen by a dietitian and put on a replenished energy and protein diet (REAP). Supplements are also used. One resident has a menu plan devised by the dietitian just for the resident as the normal menu could not be tolerated. Snacks are available at any time. All resident/families interviewed were satisfied with the meals.</p> <p>The food control plan was verified on 4 April 2019.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files reviewed indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were reviewed. Overall the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but were not limited to) nutrition, pain, pressure injury, continence and behaviour.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are</p>	<p>FA</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provided detail to guide care. Resident files reviewed included (but not limited to) management of a leg ulcer, peg feed, rosacea and palliative care. All included interventions to support care. Short-term care plans are used for some changes in health status, such as</p>

<p>consumer focused, integrated, and promote continuity of service delivery.</p>		<p>wounds and pressure injuries but staff prefer to update the long-term care plan. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, gerontology nurse specialist, dietitian, dermatologist, mental health care team for older people. and vascular clinic. The care staff interviewed advised that the care plans were easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans reviewed had interventions documented to meet the needs of the resident and there was documented evidence of care plans being updated as residents' needs changed.</p> <p>Resident falls are reported on accident forms and written in the progress notes. Neurological observations were not always completed when there was an unwitnessed fall.</p> <p>Care staff interviewed stated there were adequate clinical supplies and equipment provided, including continence and wound care supplies. Wound assessment, wound management and wound evaluation forms were in place for all wounds. Wound monitoring occurred as planned. There are currently eight wounds being treated (including one stage one pressure injury). There was documented evidence of GP and wound nurse specialist involvement in wound care. Photos were taken for each wound. There was also documented evidence of referrals to a dermatologist and the vascular clinic. There is pressure injury equipment available such as air mattresses, roho cushions and turning charts.</p> <p>Monitoring forms are in use as applicable such as weight, pain, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There are three activities coordinators who cover seven days between them. One coordinator is currently completing the diversional therapy course. Two work in the hospital and there is always one in the dementia unit from 1 pm to 7 pm. On the day of audit residents were observed listening to newspaper reading, playing bingo, participating in a church service and going for walks. Residents from the dementia unit have a separate programme but can participate in activities in the hospital if appropriate. This was witnessed at the church service.</p> <p>There is a weekly programme in large print in each resident's room and on noticeboards in all areas. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, bingo, news from the paper, music, quizzes and games. There is a monthly men's club and a monthly ladies coffee group. Happy hour is also monthly.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if</p>

		<p>there is anything they need and to have a chat.</p> <p>There is a monthly Anglican communion and a Catholic communion each Saturday. There are also fortnightly Church of Christ services and the Greenlane Christian Centre visits monthly.</p> <p>There are van outings twice a month. They go for drives, out for coffee, shopping, visit libraries and visit other CHT facilities. Special events like birthdays, Easter, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated. There are entertainers who visit.</p> <p>The facility has two cats, three canaries and two budgies. There is also weekly pet therapy.</p> <p>There is community input from a local Māori preschool on a regular basis and occasional visits from schools.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity component of the long-term care plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan.</p> <p>Resident meetings are held six monthly but there are feedback forms that residents may complete.</p> <p>There are two disabled YPD residents who enjoy massage, aromatherapy, nail treatment and being taken for walks. One YPD resident just enjoys joining in all the activities while one other is very independent and goes out on a scooter to community events and visits friends.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Except for two relatively new admissions all care plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are part of the long-term care plan and area also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan and if resident goals had not been met.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the dietitian, hospice, gerontology nurse specialist, a dermatologist, mental health services for older people and the vascular clinic. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>

<p>access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets were available. Sharps containers are available and meet the hazardous substances regulations for containers. All staff have had chemical training.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 19 October 2019. There is a maintenance person who works full time five days a week over three CHT sites. There is a gardener who works two days a week. Contracted plumbers and electricians are available when required. Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. There are two lifts between first and ground floor. Both have been serviced. In the hospital the communal lounges, hallways and bedrooms are carpeted. In the dementia unit the communal lounges, hallways and bedrooms have vinyl flooring. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>The external areas and gardens were maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. The dementia unit has a large enclosed garden.</p> <p>HCA's interviewed stated they have adequate equipment to safely deliver care for hospital and dementia level of care residents.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>All rooms have ensembles. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are signs on all shower/toilet doors.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All rooms are single. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age</p>	<p>FA</p>	<p>There are large and small lounges. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. The dining rooms are spacious. There is a hairdressing salon.</p>

appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is done off site. Laundry is bagged in the appropriate coloured bag and taken to the delivery suite where it is picked up and transported by truck to the laundry facility. The clean laundry is bagged in the appropriate bags and transported back to St Johns by truck. It is picked up from the delivery suite by staff and distributed to linen cupboards or residents. There are laundry and cleaning manuals. Internal cleaning audits are completed. The cleaners' equipment was attended at all times or locked away. All chemicals on the cleaner's trolley were labelled. There is a sluice room on the ground floor for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice room is kept closed when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The fire evacuation plan has been approved by the fire service 4 May 2016. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation drills occur last on 23 May 2019. Fire training and security situations are part of orientation of new staff and ongoing as part of the annual planner. There are adequate supplies in the event of a civil defence emergency including food and gas cooking. There are five ceiling tanks holding 1,000 litres each and are automatically activated in an emergency. There is emergency lighting and a generator available. The service emergency systems were fully utilised in April 2018 for a period of four days when there was a power outage due to stormy weather. A section 31 was sent to HealthCERT.</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 at high risk of falls have a second call bell attached to their chairs. Residents were observed to have their call bells in close proximity. The building is secure after hours with all external doors linked to the alarm system.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. There is underfloor heating. Staff and residents interviewed stated that this is effective. There is one outdoor area where residents smoke. All other areas are smoke free. Smoking cessation programmes have been offered.</p>

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		
Standard 3.1: Infection control management 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.	FA	There is an infection control coordinator (RN) who is responsible for infection control across the facility. The coordinator liaises with and reports to the unit manager. The responsibility for infection control is described in the job description. The coordinator collates monthly infection events and reports. The infection control programme is reviewed annually by the IC coordinator and CHT head office. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There was a scabies outbreak in 2018.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IC coordinator is an experienced RN and has worked at CHT St Johns for twelve years. She has access to infection control expertise within the DHB, wound nurse specialist, Public Health, Bug Control and laboratory. The GP monitors the use of antibiotics.
Standard 3.3: Policies and procedures	FA	The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection and training and education of staff. Infection control procedures

<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>		<p>developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies were developed by an external infection control specialist (CHT head office).</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The IC coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme. Staff have participated in IC education in the last year and there is training planned for 2019.</p> <p>Resident education occurs as part of providing daily cares and as applicable at resident meetings.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control</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 has been one scabies outbreak (two residents). Notification was made to Public Health.</p> <p>Policies and procedures document infection prevention and control surveillance methods. Infection control internal audits have been completed. Trends are identified and quality initiatives are discussed at quality, health and safety meetings. The systems in place are appropriate to the size and complexity of the facility. Infection rates have</p>

programme.		generally been low.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. The service has actively reduced the use of restraints over the past year to one resident with restraint (bedrails) and two residents with an enabler. The two enabler files reviewed documented that enabler use was voluntary. All necessary documentation has been completed in relation to the one restraint. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS8134.0. Staff receive training/education on restraint/enablers and restraint is discussed as part of the quality and clinical staff meetings. A registered nurse is the designated restraint coordinator.
<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>	FA	A registered nurse is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner. There is an annual CHT study day with all restraint coordinators that includes education/refresher on restraint minimisation and safe practice.
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to</p>	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in the one restraint and two enabler resident files reviewed. The restraint coordinator, the resident and/or their representative/EPOA and a medical practitioner were involved in the assessment and consent process. In the files reviewed, assessments and consents were fully completed.

use of restraint.		
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation policy 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 restraint reviewed. The service has a restraint and enablers register, which is updated each month and a report forwarded to the quality/health and safety meeting.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every six months. In the file reviewed, evaluation of restraint use had been completed with the resident, family/whānau and restraint coordinator in conjunction with the six-monthly care plan evaluation. The restraint use is reviewed monthly by the restraint coordinator.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	CI	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. For 2018 there were 10% of the 70 hospital level residents with restraint. There were no restraints in the two dementia care suites (20 beds). The service implemented restraint minimisation strategies to successfully reduce to one restraint in use for the 70-bed hospital and 20 beds dementia care facility.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>When a resident has a fall, they are checked for injuries and the GP is notified if required. The fall is reported on an accident form and in the progress notes. Family are notified unless requested otherwise. Neurological observations had not been completed for all unwitnessed falls or where there was an obvious knock to the head.</p>	<p>Five of seven resident unwitnessed falls had no neurological observations completed as per protocol.</p>	<p>Ensure all unwitnessed falls have neurological observations completed as per protocol.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>CHT St Johns was one of 10 aged care facilities invited to participate in the year-long SHARE (supportive hospice and aged residential exchange) programme in collaboration with the Hospice and the Auckland University School of Nursing. SHARE is a new model of palliative care that has been designed to integrate and improve palliative care in residential aged care. The programme has strengthened the relationship between the</p>	<p>A specialist palliative care nurse was assigned to the service and visited weekly to provide clinical coaching and role modelling to help RNs and HCAs put learning into practice. A specific assessment tool – supportive and palliative care indicators tool – was used to identify residents with a life-limiting disease/condition requiring palliative care needs and who are likely to be in their last year of life. Staff learned that palliative care preparation is essential for the patient/carer/support person/family and other members of the health care team. Goals of care are focused around optimising quality of care, maximising community support, early symptom management and advance care planning. With the support of the palliative nurse specialist CHT St Johns entered 44 residents into the palliative care register. Among the identified residents 31 (71%) died within a year as anticipated and prepared for by the staff, family and health care team. In conclusion SHARE has been a timely learning experience for both parties and residents and family were more prepared and supported through their palliative care/end</p>

		<p>hospice staff and healthcare staff and has developed staff confidence to deal with residents with more specialised care such as palliative care, end of life and last days of life care.</p>	<p>of life journey.</p> <p>The service has evidenced that by implementing the specific assessment tool for all residents entering residential care that residents requiring support and interventions for life limiting illnesses are being managed better and earlier therefore improving their quality of life and time with their loved ones. Testimonials from palliative care specialists confirm the service is providing improved palliative care and staff skills and knowledge has improved. Emails and letters from families confirm they have been well supported through their end of life journey.</p>
<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>	<p>CI</p>	<p>Data collected and collated for falls across the hospital and dementia care unit evidenced falls for dementia care residents have remained below the St Johns average over the last year.</p>	<p>Data collected and collated are used to identify areas that require improvement. Clinical indicator data has individual reference ranges for acceptable organisational limits. A quality improvement project implemented in January 2019 was to reduce the numbers of falls across the hospital and dementia level of care residents.</p> <p>Residents falls are monitored monthly with strategies implemented to reduce the number of falls including: highlighting residents at risk, clinical assessments for underlying causes, GP reviews including medications, physiotherapy assessments, review of the residents environment, ensuring the residents mobility plan is current, implement falls prevention equipment such as low beds (to lessen the impact of injury with falls), bed sensors, pull string monitors on lounge chairs, intentional rounding for all high risk residents and increased staff awareness and staff falls prevention education. Residents with one or more events had a re-assessment of falls risk. A review of falls identified the critical time for falls happened between 1-3 pm and 5-7 pm which was at the time of handovers and meal breaks. There has been changes made to practice around the critical times. Data collated reflected a high number of falls in the dementia unit. Over the 1-3 pm and 5-7 pm critical times for falls there is float shift, RN and activity coordinator to monitor residents who are high falls risk and wanderers. Data reviewed over 2019 to date showed 11 falls for January reducing to below 5 per month for the last three consecutive months. Hospital level resident falls while reducing,</p>

			have not been consistently below the CHT St Johns benchmark level. The service has been successful in reducing falls and falls with injury for dementia care residents.
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>	CI	<p>For 2018 there were 10% of the 70 hospital level residents with restraint. There were no restraints in the two dementia care suites (20 beds). The service implemented restraint minimisation strategies to successfully reduce to one restraint in use for the 70-bed hospital and 20 beds dementia care facility.</p>	<p>The restraint coordinator (senior RN) developed an action plan to reduce restraint use that included reassessments, discussion with residents and family regarding safety concerns and alternatives to restraint, education with staff on alternative strategies and increase in engagement of activities with residents from the DT and HCAs. The use of low beds, bed sensors, fall out mattress and one hourly monitoring are implemented for residents at risk of falls. The service has reduced the number of restraints from seven to one for 2019 to date.</p>

End of the report.