

CHT Healthcare Trust - St Margaret's Hospital and Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	CHT Healthcare Trust
Premises audited:	St Margaret's Hospital and Rest Home
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: 26 September 2019 End date: 27 September 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	85

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

St Margaret's is part of the CHT group of facilities. The facility is purpose-built providing three levels of care (hospital – geriatric/medical, residential disability, rest home and dementia) for up to 87 residents. On the day of audit there were 85 residents. The residents and relatives spoke positively about the care provided.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with family, management, staff and the general practitioner.

There were no areas for improvement identified at this audit.

The service is commended for achieving continuous improvement ratings around activities, nutrition, restraint minimisation and infection surveillance.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on noticeboards. Policies are implemented to support rights such as: privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Family stated they are kept well informed on their relative's health status. Residents are encouraged to maintain links with the community. Complaints processes are implemented, and complaints and concerns are managed appropriately.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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There is a business plan with goals for the service that has been regularly reviewed. St Margaret's has a fully implemented, robust quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has a training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

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

There is a comprehensive admission package available prior to, or on entry to the service. The 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/whānau input. Care plans viewed demonstrated service integration and are reviewed at least six monthly. Resident files included medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and healthcare assistants responsible for the administration of medicines complete education and medication competencies. Medication charts are reviewed three monthly by the general practitioner.

The activities coordinator's and staff 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. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks 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.
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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. All residents' rooms have ensuites and there are sufficient communal showers/toilets. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are constructed for ease of resident access and ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system and surveys. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. There is a trained 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.
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There are policies and procedures on safe restraint use and enablers. A registered nurse is the restraint coordinator. On the day of the audit, there were two residents with restraints in use (bed rails) and four residents with a lap belt as an enabler. Staff receive training around restraint and challenging behaviours. Assessment, monitoring and evaluation is well documented.

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.

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

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 (clinical coordinator) is responsible for coordinating education and training for staff. The infection control coordinator has completed annual external training. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	4	46	0	0	0	0	0
Criteria	4	97	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>There are policies and procedures in place around resident rights. Discussion with nine healthcare assistants, one clinical coordinator and three registered nurses (RN), one enrolled nurse (EN), and two activities staff identified that they are aware of The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) and could describe the key principles of residents' rights when delivering care.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>Informed consent processes were discussed with residents and families on admission. Informed consents for photographs, release of medical information, outings, flu vaccinations and medical cares were signed. Discussions with registered nurses confirmed that staff understand the importance of obtaining informed consent for providing personal care and accessing residents' rooms.</p> <p>Enduring power of attorney (EPOA) evidence was filed in the residents' electronic charts and activated where required.</p> <p>Advance directives for health care including resuscitation status had been completed where residents were deemed to be competent. Where residents were deemed incompetent to make a resuscitation decision the GP had made a medically indicated resuscitation decision. There was documented evidence of discussion with the</p>

consent.		family. Resident files showed evidence that where appropriate the service actively involved family/whānau in decisions that affected their relative's lives.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Resident advocates are identified during the admission process. Pamphlets on advocacy services are available at the entrance. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy services. Staff receive education and training on the role of advocacy services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The service has an open visiting policy and family/whānau and friends are encouraged to visit the home and are not restricted to visiting times. All residents interviewed confirmed that family and friends are able to visit at any time and visitors were observed attending the home. Residents and relatives verified that they have been supported and encouraged to remain involved in the community.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy/procedure in place and the complaints process is provided to residents and relatives on entry to the service, complaints forms are available to residents and relatives. A record of all complaints is maintained on the on-line complaint register. The facility manager manages complaints. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints and discussion around concerns, complaints and compliments are evident in facility meeting minutes. Discussion around concerns, complaints and compliments are evident in facility meeting minutes Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in manager and staff meetings. Nineteen complaints for 2018 and 11 complaints from 2019 year to date have been documented as resolved with appropriate corrective actions implemented. Of the complaints reviewed, one complaint was lodged with the HDC advocacy service (March 2018) and remains open. No complaints were lodged with the HDC Commissioner since the previous audit. The Ministry requested follow up against aspects of a complaint that included training and wound management. There were

		no identified issues in respect of this complaint.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The service has information available on The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) at the main entrance to the facility. The Code (English and te reo Māori) is also displayed in the resident areas. There is a welcome information folder that includes information about the Code. The resident, family or legal representative has the opportunity to discuss this prior to entry and/or at admission with the clinical manager. Nine residents (five rest home including one YPD respite and four hospital level of care) and nine relatives (seven hospital level, one rest home and one dementia level of care) interviewed, confirmed that information has been provided around the code of rights. Residents stated that their rights are respected when receiving services and care. Residents and relatives stated they receive sufficient verbal and written information to be able to make informed choices on matters that affect them. There is specific information around dementia care provided to relatives and visitors.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff could describe how they maintain resident privacy, including knocking on the residents' doors before entering, as observed on the day of audit. Education around privacy and dignity, prevention of abuse and neglect in-service is provided as part of the education plan. Resident's cultural, social, religious and spiritual beliefs are identified on admission and included in the resident's care plan/activity plan.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are cultural awareness policies and a Māori health plan to guide staff in the delivery of culturally safe care. A Māori staff member provides blessings for the site and prayers as needed. There were three residents who identify as Māori on the day of audit. Resident files included interventions related to Māori culture, tribal affiliations and whānau. Local kapa haka groups visit St Margaret's.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Care plans are reviewed at least six monthly to ensure the resident's individual culture, values and beliefs are being met. The service caters for a number of different ethnicities including Māori, Chinese, Samoan, Tongan and eastern European. Care plans reviewed included specific interventions related to individual residents cultural and spiritual needs. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with weekly church services and visiting clergy who provide pastoral care.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The staff employment process meets best practice with regard to recruitment, including reference checks and police vetting. Professional boundaries are defined in job descriptions. Staff were observed to be professional within the culture of a family environment. Caregivers interviewed were able to describe how they recognise and report any suspected abuse and the service's zero tolerance policy. Residents interviewed stated that they are treated fairly and with respect.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has implemented policies and procedures that provide a good level of assurance that it is adhering to relevant standards. Healthcare assistants and registered nurses (RNs) have access to internal and external education opportunities. The service is promoting the attainment of NZ qualifications standards with five on site assessors employed at St Margaret's. Six Healthcare assistants are trained as Careerforce observers. Regular facility and clinical meetings and shift handovers enhance communication between the teams and provide consistency of care. The service has quality teams with an RN as a team leader around wound care, falls prevention, a nutrition programme (REAP), infection control, continence, pressure injury prevention management and restraint prevention. These have been effective at maintaining high standards at other CHT facilities for the manager. The service employs a physiotherapist for eight hours per week over one dedicated day, who assesses all new residents and completes resident mobility assessments and fall reviews. The physiotherapist provides safe manual handling training for staff every two months. The service has contributed towards positive resident outcomes by implementing monthly multi-disciplinary meetings incorporating polypharmacy and drug rationalisation reducing adverse medication effects. All residents and families speak positively about the care provided.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Management promote an open-door policy. Relatives/residents are aware of the open-door policy and confirmed on interview that the staff and management are approachable and available. Residents/relatives have the opportunity to feedback on service delivery through resident meetings and annual surveys. The resident meetings are bi-monthly and are attended by the kitchen manager and external speakers. Residents and relatives receive seasonal newsletters four times a year.</p> <p>Accident/incident forms reviewed documented that relatives have been notified of the incident. Relatives interviewed stated they are notified promptly of any changes to resident's health status.</p> <p>Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. An interpreter service is available if required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>St Margaret's is part of the CHT group of facilities. The building is a purpose-built single level facility providing hospital – geriatric/medical, rest home, dementia and younger persons with a disability care (YPD) for up to 87 residents. On the day of audit there were 85 residents cared for across seven dual-purpose units and one 20 bed dementia unit. There were 57 hospital residents including three on YPD contracts (one of whom was on an interim care contract) and one on an ACC contract, nine rest home level residents including one YPD on a respite contract in the dual-purpose units and 19 residents in the 20-bed secure dementia unit. All other residents were under the age-related residential care services agreement. The organisation has a philosophy of care, which includes a mission statement.</p> <p>The unit manager is a registered nurse who has been in the role for five years, has postgraduate qualifications related to facility management and regularly attends monthly CHT management training in Auckland.</p> <p>The clinical coordinator is a registered nurse who was appointed to her role in 2016. She is currently completing a master's qualification and regularly attends CHT training. All competencies and training requirements were current.</p> <p>The unit manager reports to the area manager weekly on a variety of operational issues. The unit manager has completed in excess of eight hours of professional development in the past 12 months.</p> <p>A CHT strategic plan includes business plan targets for 2019. St Margaret's has set a number of quality goals and these also link to the organisation's strategic goals. The unit managers performance plan is aligned to CHTs strategy and business plan.</p>
<p>Standard 1.2.2: Service Management</p>	<p>FA</p>	<p>During the temporary absence of the facility manager the clinical coordinator will provide management oversight of the facility with the support of the area manager.</p>

<p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The performance plan for the facility includes quality goals (strategic themes) with associated actions, milestones and dates achieved. The unit manager advised that she is responsible for providing oversight of the quality programme. Interviews with staff confirmed their familiarity with the quality and risk management systems that have been put into place.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed and updated at the organisational level. New policies or changes to policy are communicated to staff in the staff meetings.</p> <p>A range of data (eg, falls, laundry incidents, property incidents, complaints, staff incidents, medication errors) are collected, collated and analysed at head office and shared with staff at health and safety/quality and staff meetings. A comprehensive internal audit that covers all aspects of the service against the health and disability sector standards is completed six-monthly by the area manager (last completed March 2019 and October 2018). There was evidence in the staff meetings in 2019 to verify staff were informed of the internal audit results. Other audits including infection control and restraint are also completed as per the internal audit schedule. The data is analysed, and trends are identified through a comprehensive data management system. Monthly comparisons including benchmarking against other CHT facilities include trend analysis and graphs. Areas of non-compliance identified through quality activities are actioned for improvement. Interviews with staff confirmed that quality data including trends, are discussed at monthly staff/quality meetings to which all staff are invited.</p> <p>Resident satisfaction surveys are regularly sent to residents and family. Survey results are collated, trended and analysed and results are shared with staff and family at meetings and minuted. Interview with family confirmed that individual concerns and opportunities for improvement are addressed.</p> <p>Bi-monthly health and safety/quality meetings alternate with full staff meetings and minutes document discussions around accident/incident data, health and safety, infection control, and concerns. Minutes are available for staff to read in a folder at the nurses' station. Clinical meetings are held monthly and minutes</p>

		<p>reported discussion around falls prevention, continence, wound care, weight, nutrition (REAP), restraint and infection control. Resident/family meetings take place on a bi-monthly basis.</p> <p>A health and safety programme is in place that meets current legislative requirements. An interview with the health and safety officer (RN) and review of health and safety documentation confirmed that legislative requirements are being upheld. External contractors and all new staff have been orientated to the facility's health and safety programme. The hazard register was up to date and is regularly monitored by the health and safety officer. The facility is currently undergoing internal repainting. A management plan ensuring resident safety included resident and family notifications and alternative accommodation while rooms were undergoing renovations.</p> <p>Strategies are in place to reduce the number of residents' falls. All new residents and residents who have experienced a fall are assessed by a physiotherapist and individual plans to minimise future falls are implemented. Sensor mats are used for those residents who are at risk of falling.</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>The service collects incident and accident data on forms, which are collated monthly and are discussed at the staff meetings, quality and health and safety meetings.</p> <p>Sixteen incident forms were reviewed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents. The healthcare assistants interviewed could discuss the incident reporting process. The clinical coordinator collects incident forms, investigates and reviews, and implements corrective actions as required.</p> <p>The facility manager interviewed could describe situations that would require reporting to relevant authorities. There have been six section 31 reports to the Ministry of Health since the previous audit including three pressure injuries, one RN rostering and two other.</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 resource management policies in place that include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of current practising certificates are retained. Nine staff files (one clinical coordinator/RN, two staff RNs, four HCAs, one diversional therapist and one activities coordinator) reviewed, evidenced implementation of the recruitment process, employment contracts and annual performance appraisals.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and remarked that new staff were adequately orientated to the service. Evidence of an orientation programme being completed was sighted</p>

legislation.		<p>in the staff files reviewed of staff who had been hired by CHT.</p> <p>There is an annual education plan that is being implemented that includes in services and completion of online education modules. Training includes specific education related to caring for younger people. The competency programme is ongoing with different requirements according to work type. The unit manager, clinical coordinator and registered nurses are able to attend external training, including sessions provided by the local DHB. Over eighty percent of the healthcare assistants have attained NZ standards qualifications. Eight of the ten registered nurses employed have completed interRAI training.</p> <p>Of the 15 healthcare assistants working in the dementia unit, seven have completed required dementia standards. Six HCAs are enrolled for required dementia units and have commenced employment in the unit within the last six months. One recently employed HCA has not yet enrolled. All RNs have a current first aid certificate.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Policy is in place to determine staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The manager and clinical coordinator are on duty during the day Monday to Friday. Both share the on-call requirement for clinical concerns month about with the second on call providing backup.</p> <p>The facility has seven suites (each suite has either 8, 9 or 10 resident rooms).</p> <p>Healthcare assistants are staffed according to suites.</p> <p>Residents and relatives stated there are adequate staff on duty at all times. Staff stated they feel supported by the management team who respond quickly to after hour calls.</p> <p>Across the facility, there are three RNs working morning shifts (three long shifts) and three RNs on afternoon shift (two long and one short) and one RN on night shift.</p> <p>There are two activities staff on Monday to Friday and one activity staff for the whole facility in the weekend.</p> <p>There are four HCAs and one RN on night shift across the six-rest home and hospital suites. There is one HCA rostered in the Sunflower dementia unit at night.</p> <p>Suite A – 10 beds (9 hospital residents)</p> <ul style="list-style-type: none"> • AM shift - 2 HCAs (one long shift, one short) • PM shift – 1 HCA (one long shift) and 1 HCA floater 4 pm – 8 pm between suite A, B, C <p>Suite B – 10 beds (9 hospital & 1 rest home residents)</p> <ul style="list-style-type: none"> • AM shift - 2 HCAs (one long, one short shift)

		<ul style="list-style-type: none"> • PM shift – 1 HCA (one long shift) <p>Suite C – 10 beds (10 hospital residents)</p> <ul style="list-style-type: none"> • AM shift - 2 HCAs (one long shift, one short) • PM shift – 1 HCA (one long shift) <p>Suite D- 10 beds (9 hospital & 1 rest home residents)</p> <ul style="list-style-type: none"> • AM shift - 3 HCAs (two long, one short shift) • PM shift – 2 HCA (two long shift) and 1 HCA floater 4 pm – 8 pm between suite D, E <p>Suite E – 10 beds (9 hospital & 1 rest home hospital)</p> <ul style="list-style-type: none"> • AM shift - 2 HCAs (one long shift, one short) • PM shift – 1 HCA (one long shift) <p>Suite F and Suite G (11 hospital and 6 rest home residents on the day)</p> <ul style="list-style-type: none"> • AM shift 3 HCAs (two long, one short shift) • PM shift – 1 HCA (one long shift); 1 HCA floater 4 pm – 8 pm between suite F & G <p>Sunflower 20 beds (19 dementia)</p> <ul style="list-style-type: none"> • AM shift - 3 HCAs (two long shifts, one short) • PM shift – 1 HCA (two long shift). <p>At the time of the audit acuity was reported to be evenly spread throughout the facility. Staffing can be flexible to cover changes in acuity. Extra staff can be called on for increased resident requirements. A stable staff means there are a sufficient number of experienced staff to cover each shift. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents. Staff confirmed on interview that management are responsive to after hour calls.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded,</p>	<p>FA</p>	<p>There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the resident’s individual record and resident register. Resident clinical and allied health records are integrated. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation.</p>

current, confidential, and accessible when required.		
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	Comprehensive admission information packs on rest home and hospital level of care and services available are provided for families and residents prior to admission or on entry to the service. Admission agreements reviewed were signed and aligned with contractual requirements. Exclusions from the service are included in the admission agreement.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	The service has transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and 'the yellow envelope' is used. The RNs reported that they include copies of all the required information in the envelope.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>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.</p> <p>The facility uses a robotic sachet system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses, the enrolled nurse and medication competent carers administer medications in the hospital, rest home and dementia care unit. Medication competencies are updated annually, and staff attend annual education. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature is checked daily. Eye drops are dated once opened. There were no residents self-medicating on the day of the audit, policies and procedures were in place in the event that residents were self-medicating; with medications being kept in locked drawers; and the requirement for residents to be deemed competent.</p> <p>Registered nurses use an electronic medication management system and sign for the administration of medications. Twenty medication charts were reviewed. Medications have been reviewed at least three monthly by the GP. Photo ID and allergy status are recorded. 'As required' medications have 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 are met where this service is a component of service delivery.</p>	<p>CI</p>	<p>The service employs a contract company to provide all meals. There is a food control plan in place which expires on 20 April 2020. There are two cooks who, between them, cover all shifts. There are also two kitchenhands on during the day. All have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen.</p> <p>There is a well-equipped kitchen and all meals are cooked on site. Meals are served directly from a mobile hot box in all dining rooms. Special equipment such as lipped plates are available. On the day of audit, meals were observed to be well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These were all within safe limits.</p> <p>Residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. The four-weekly seasonal menu cycle is written and approved by an external dietitian. Meals in the dementia facility are served on coloured plates to enhance presentation. Additional snacks are always available in the dementia unit.</p> <p>The chef manager, clinical coordinator and registered nurses described the "Replenish, Energy and Protein" (REAP) programme, a New Zealand-wide initiative that has been implemented to enhance the nutritional status of residents.</p> <p>All resident/families interviewed were happy with the meals. The chef manager advised she attends resident meetings and speaks with resident's one-to-one to gain feedback on food satisfaction.</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 potential residents should this occur and communicates this to potential 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 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 sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files contained appropriate assessment tools and assessments that had been reviewed at least six monthly or when there was a change to a resident's health condition. The interRAI assessment tool was implemented and completed for all long-term residents under the Age-Related Residential Contract (ARC). Care plans sampled had been developed based on these assessments.</p> <p>Assessments for wounds and pressure injuries included details of wound characteristics and dimensions. Photographs for some wounds were evident on resident's files.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The ten resident files reviewed identified that care plans were resident-focused. Care plans reviewed evidenced multidisciplinary involvement in the care of the resident.</p> <p>Short-term care plans (STCPs) were in use for changes in health status and wounds and pressure injuries. The auditor reviewed wound management plans for the 24 wounds and one pressure injury. STCPs reviewed had been evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan if there was an ongoing problem.</p> <p>There is evidence of service integration with documented input from a range of specialist care professionals including: the wound care specialist nurse, GP, podiatrist, physiotherapist, dietitian and mental health care team for older people. The care staff advised that the care plans are easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff stated they notify family members about any changes in their relative's health status. All long-term care plans sampled, had interventions documented. Care plans had been updated as residents' needs changed. Resident falls were reported on incident forms and written in the progress notes.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and evaluation forms were in place for all wounds. Wound monitoring occurred as planned. On the day of the audit there were 18 wounds in the hospital, six wounds in the dementia unit and no wounds in the rest home. There was a facility acquired pressure injury in the hospital, this was healing and on the day of the audit it was a grade two. It had previously been a grade three and a section 31 had been completed and submitted. The facility had accessed wound care specialist advice for this wound.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs, pain, activities, wounds and neurological</p>

		observations as required. Behaviour charts are used for any residents that exhibit challenging behaviours.
<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>	CI	<p>There are four activities coordinators, they cover seven days a week and lead the activities. Caregivers also provide some of the activities. The dementia unit has a dedicated activities programme which is facilitated by the activity coordinator and caregivers. On the days of audit residents went on a bus trip and later watched a seventy's movie. The theme for the month was the "1970s".</p> <p>There is a weekly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities in which they can participate. These include (but are not limited to) exercises, walks outside, gardening, balloon tennis, crafts, games and quizzes. There are weekly bible class services. Those residents who prefer to stay in their room have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There are outings twice a week, the facility hires a wheelchair accessible van for this. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day and Anzac Day are celebrated. Visiting community groups include choirs, library, kindergartens, children's groups, children's music school, canine friends, SPCA and Pets Assisting Therapy.</p> <p>A cultural month has become an annual occurrence at St Margaret's which has created positive outcomes for residents, their families, staff and the community.</p> <p>Residents in the dementia unit have resident-specific activity plans in place. Caregivers provide much of the activities in the dementia unit, guided by the activity plan and resident's own activity plan. Some dementia residents attend activities in the main rest home.</p> <p>Residents under the age of 65 years have activities detailed on their activity plan that meets their specific needs. Discussion with these residents and activities attendance calendars indicated that the activities programme met their needs.</p> <p>Residents have a lifestyle questionnaire completed after admission, that describes hobbies and interests, career and family by the resident, their family and the nurse. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan.</p> <p>Surveys received indicated above average levels of satisfaction with the activities programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service</p>	FA	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term nursing care plan had been evaluated at least six-monthly or earlier if there was a change in health status. There was at least a three-monthly review by the GP. Resident files sighted demonstrated that short-term care plans were evaluated and resolved or added to the long-term care plan if the</p>

<p>delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>problem is ongoing.</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>	<p>FA</p>	<p>Referral to other medical and non-medical services is evident in resident files reviewed. Referral documentation is maintained on resident files. There was evidence that residents had been referred to the dietitian, speech and language therapist and mental health services for older people. There was also evidence of input from the physiotherapist and hospice.</p> <p>Discussion with the registered nurse confirmed that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p> <p>On the day of the audit there was one pressure injury and 24 wounds. There had been external input, or the GP was aware of all wounds except the two new small skin tears. External input included but was not limited to GP, wound care specialist nurse, surgeons, hospice and emergency department.</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. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals are clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharps containers are available in the sluice rooms. The hazard register identifies hazardous substances and staff indicate a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. The registered nurses described the safe management of hazardous material.</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</p>	<p>FA</p>	<p>The building holds a current Building Warrant of Fitness which expires on 16 September 2020. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged. All hoists and scales have been checked and tagged. Hot water temperatures have been monitored in resident areas and are within the acceptable range. The communal lounges and hallways are carpeted. The utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Residents' rooms, ensuites and communal showers and toilets have nonslip vinyl flooring. Residents were observed moving freely around the areas with mobility aids where required. The external</p>

purpose.		areas, courtyards and gardens are well maintained. All gardens have attractive features and are easily accessible to residents. The dementia unit has a walking pathway, gardens and raised garden beds. All outdoor areas have some seating and shade. There is safe access to all communal areas.
<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	All rooms have single occupancy except for one room shared by a married couple (there was enough space for both beds in this room). All rooms have ensembles, toilets and sink. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are well maintained and easy to clean. There is ample space in all toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are privacy signs on all shower/toilet doors. There are visitor toilets available in the main corridor.
<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	Residents' rooms are spacious and allow care to be provided and the safe use of mobility aids. Staff reported that they have more than adequate space to provide care to 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</p>	FA	The rest home/hospital area is divided into seven 'suites', each with an individual open plan lounge/dining area. Additionally, there is a large communal lounge. The dementia unit has two lounges, a quiet area and a dining area. There are spaces where residents, who prefer quieter activities or visitors, may sit. Some lounges open out onto attractive gardens. The communal lounges are also used as dining rooms.

<p>their relaxation, activity, and dining needs.</p>		
<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>	<p>FA</p>	<p>Laundry services are contracted to an external service. There is a washer and dryer available for laundering of some personal clothing. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended or locked away in the cleaners' room as sighted on the day of the audit. Cleaning is done by on-site cleaners who are contracted by an external service. There are three sluice rooms for the disposal of soiled water or waste. The sluice room and the laundry are 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>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. There is a staff member with a first aid certificate on duty at all times. The facility has a fire evacuation plan that has been approved by the fire service on 7 November 2008. A fire drill is completed as part of the orientation of all new employees and six monthly. Smoke alarms, sprinkler system and exit signs are in place. Two gas barbeques and torches are available in the event of a power failure. A contract with a generator company is in place to supply and install generators as required.</p> <p>Emergency lighting is in place. A civil defence kit is in place. Supplies of stored water is in tanks. Electronic call-bells were evident in resident's rooms, lounge areas and toilets/bathrooms. All call bells have an emergency button available and all bells alert on electronic panels visible throughout each suite. All call points are physically and visually checked monthly by the maintenance worker for the site. There is a keypad lock into the dementia unit.</p> <p>The security policies are being implemented around locking of the facility from dusk to dawn. Staff lock the facility at night and processes are in place should additional security be required.</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</p>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. The facility was a warm and comfortable temperature on the day of the audit. Residents interviewed confirmed the temperature was good.</p>

comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control coordinator is an RN who has completed an infection control course. The infection control coordinator oversees infection control for the facility and is responsible for the collation of infection events. The infection control coordinator has a defined job description. Infection events are collated monthly and reported to combined infection control and health and safety.</p> <p>The infection control programme has been developed by the CHT management team infection control team and is linked to the quality system. The IC programme has been reviewed annually.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator has attended external infection control and prevention control education, including CHT and DHB infection control nurse meetings, and leads the infection control focus group.</p> <p>The combined infection control/health and safety committee form part of the quality risk committee. The committee meets monthly to discuss infection control events and quality data as evidenced in meeting minutes.</p> <p>The infection control coordinator has access to GPs, local laboratory, the infection control nurse specialist at the DHB and public health departments at the local DHB for advice and an external infection control consultant specialist.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures</p>	FA	<p>The infection control policies include a comprehensive range of standards and guidelines, including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are reviewed regularly by the CHT senior management team.</p>

are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule.</p> <p>Resident education is expected to occur as part of providing daily cares as appropriate.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	CI	<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 no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit there were two residents with restraints in use (bed rails) and four residents using a lap belt as an enabler. Two resident files were reviewed for enabler use and identified the residents had given voluntary consent.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and</p>	FA	<p>A registered nurse is the restraint coordinator with a defined job description, she also leads the restraint focus group. Restraint discussion and quality data around restraint and enabler use is included in the quality/risk meetings and clinical meetings. Care staff receive education on safe restraint use at orientation and annually. There is ongoing education including challenging behaviours.</p>

ongoing education on restraint use and this process is made known to service providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. The RN in partnership with the restraint coordinator, the resident and their family/whānau undertakes assessments. Ongoing consultation with the resident and family/whānau was evident. A restraint assessment form had been completed for two resident files reviewed requiring restraint (sighted). Assessments identified risks related to the use of restraint and the specific interventions or strategies to try (as appropriate) before implementing restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Each episode of restraint is monitored at pre-determined intervals, depending on individual risk to that resident. Restraint use is recorded in the care plan; with risks and cares to be carried out during the restraint episode documented. Individual restraint monitoring forms evidenced that checks and cares had been carried out according to the documented frequency described in the monitoring tool. There is an up-to-date restraint register.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluations occur six monthly as part of the ongoing review for residents on the restraint register, and as part of their care plan review. Families (where possible) and the GP and RNs are included as part of this review.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of	CI	Restraint usage is monitored regularly. The review of restraint use is discussed at the quality risk meetings and relevant facility meetings. The facility is proactive in minimising restraint with evidence of continued reduction over the last year. Internal restraint audits are completed six monthly and demonstrated compliance of the standard. The facility has been actively minimising the use of restraints and have reduced restraint by 50% over the 12 months from January 2018 to January 2019.

restraint.		
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

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 1.3.13.2</p> <p>Consumers who have additional or modified nutritional requirements or special diets have these needs met.</p>	CI	<p>The chef manager, clinical coordinator and registered nurses described the “Replenish, Energy and Protein” (REAP) programme, a New Zealand-wide initiative that has been implemented to enhance the nutritional status of residents. All residents are assessed against criteria as being either in the REAP one or REAP two or REAP three categories. Assessment is based on body mass index, weight loss, the presence of wounds or pressure injuries. A resident on REAP two requires fortified meals; and a resident on REAP three requires nutritional supplements.</p>	<p>the “Replenish, Energy and Protein” (REAP) programme, a New Zealand-wide initiative that has been implemented to enhance the nutritional status of residents. Improvement in individual resident’s nutritional status was achieved by care staff assessing resident needs and working in partnership with kitchen staff to create a comprehensive profile of residents’ additional nutritional requirements. Cream enriched potato and extra cream for porridge is also provided for residents where nutritional enhancement is assessed as being beneficial. Data presented demonstrated that in January 2019 there were 31 residents on REAP level three, and one resident on REAP level two. In July this had reduced to only 17 residents being on REAP level three.</p>

<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>CI</p>	<p>A Cultural month was celebrated in October at St Margaret's. Due to the success of this it has become an annual event. The objective of the celebration was to create a community-wide celebration with better understanding of cultural diversity. Residents, their families, staff and the community participate in the event. The activities coordinators facilitated the event which included: bringing in family members, elders, children, children's school groups for cultural singing, kapa haka, dancing or talks; cooking demonstrations and sampling of food; teaching staff, families and residents songs, dances words and phrases and the wearing of cultural dress and movies about various countries. Cultural input included groups from Samoan, Tongan, Kiwi, Fijian, Indian, Tuvalu, Kiribati, Dutch, Filipino, and Croatian cultures.</p>	<p>A Cultural month was celebrated in October at St Margaret's. Due to the success of this it has become an annual event. The objective of the celebration was to create a community-wide celebration with better understanding of cultural diversity. Outcomes have included the following: residents of Croatian cultural descent are now more fully engaged in the daily activities programme; residents within the facility participated in activities wearing cultural dress and participating in cultural performances; evening activities included cultural activities with community groups and staff; other facilities were welcomed to join in the presentations. The grand finale included a cultural lunch. The cultural month embraces the CHT pillars of care which includes compassion (by understanding and embracing the cultural differences); companionship; comfort and quality of life. A series of photographs captured the events. Surveys received indicated above average levels of satisfaction with the activities programme.</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. All infections are individually logged monthly. The data has been monitored and evaluated monthly and annually and is benchmarked internally.</p>	<p>In 2018, the service implemented the following strategies around reducing the incidents of all infections that included: (i) review of the management of residents with chronic respiratory conditions, (ii) education on the importance of staff hand hygiene using glitter bugs to demonstrate best practise; (iii) identifying and monitoring of the organisms causing the infection (iv) antibiotic stewardship (v) education of residents especially females of correct techniques to prevent urinary tract infections, (vi) introduction of extra fluid rounds in warmer weather (vii) specifying in residents care plan the risk factors for infection and preventative management strategies. As a</p>

			result of the strategies implemented, the facility has remained consistently below benchmarking results since July 2018.
<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>facility has been actively minimising the use of restraints and promotes the safe mobilisation of residents.</p>	<p>The facility has been active in educating staff and families around alternative options to restraint despite requests from families to provide this option. Documentation identified families requesting this option were educated on an individual basis. Restraint minimisations included physio assessments, seating positions in areas where they can be closely monitored, providing activities, the use of landing mats, sensor mats and hi-low beds. Additional equipment has been purchased as required for individual residents.</p> <p>Restraint monitoring identified restraint had reduced by 75% over the 21 months from January 2018 to September 2019.</p>

End of the report.