

CHT Healthcare Trust - Haldene Rest Home

Introduction

This report records the results of a Surveillance 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:

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| Legal entity: | CHT Healthcare Trust | |
| Premises audited: | Haldene Rest Home | |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | |
| Dates of audit: | Start date: 27 February 2020 | End date: 28 February 2020 |
| 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: | 43 | |

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

General overview of the audit

CHT Halldene is owned and operated by the CHT Healthcare Trust. The service currently provides care for up to 60 residents requiring hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 43 residents.

This surveillance audit was conducted against a subset of the 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 residents and staff files, observations and interviews with residents, family, management and staff.

The service has an established quality and risk management system. A unit manager, who is well qualified and experienced for the role oversees the service and is supported by a clinical coordinator and the area manager. Residents, relatives and the nurse practitioner interviewed spoke positively about the service provided.

Six of the six shortfalls identified as part of the previous partial provisional audit have been addressed. These were around: completion of the environment for residents including a CPU, external landscaping, completing fire drills, a fire evacuation approval, and an operational call bell system.

This audit has identified areas requiring improvement around care planning.

Consumer rights

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| 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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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

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| 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. CHT Halldene 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 an orientation and 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

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| 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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Electronic care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is an electronic medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner or nurse practitioner. A range of individual and group activities is available and coordinated by the diversional therapist. All meals are prepared on site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives reported satisfaction with the food service.

Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | Standards applicable to this service fully attained. |
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The building has a current CPU and an approved emergency evacuation plan. Reactive and planned maintenance is in place. All bedrooms are single occupancy and have either their own ensuites or a shared ensuite toilet. There are sufficient communal showers. There is sufficient space to allow the safe movement of residents around the facility using mobility aids. There are

communal dining rooms and lounges and several smaller seating areas. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning contractors and laundry staff are providing appropriate services. Emergency systems and equipment are in place in the event of a fire or external disaster. There is a first aider on duty at all times and call bells are fully operational.

Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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CHT Halldene has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were two residents on restraint (one bed rail and one lap belt) and one resident with an enabler. Restraint management processes are adhered to.

Infection prevention and control

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| 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. |
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| Standards | 0 | 17 | 0 | 0 | 1 | 0 | 0 |
| Criteria | 0 | 48 | 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) |
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| 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 |
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| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The service has a complaints policy that describes the management of complaints process. There are complaint forms available throughout the facility. Information about complaints is provided on admission. Interview with two hospital and two rest home level residents demonstrated an understanding of the complaints process. All staff interviewed (five healthcare assistants, three RNs, one cook, one diversional therapist and two maintenance staff) were able to describe the process around reporting complaints. There is a paper-based and electronic complaints' register. There were eight complaints made in 2019 and one year-to-date. All complaints reviewed had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. Discussions with residents confirmed that any issues are addressed, and they feel comfortable to raise any concerns.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p> | FA | <p>There is a policy to guide staff on the process around open disclosure. The unit manager and clinical coordinator confirmed family are kept informed. Relatives (two hospital and two rest home) stated they are notified promptly of any incidents/accidents and change of health status. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised</p> |

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| communication. | | resident should they wish to do so. There is access to an interpreter service as required. |
| <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 Halldene is owned and operated by the CHT Healthcare Trust. The service provides rest home and hospital level care for up to 60 residents. On the day of the audit, there were 43 residents in total, 10 rest home level and 33 hospital level. This includes one rest home resident funded through disability support services (DSS) a ministry of Health contract. The remainder were under the ARRC agreement. All rooms are dual-purpose.</p> <p>The unit manager is a registered nurse and maintains an annual practicing certificate. She has been in the manager role at the facility for over five years. A clinical coordinator who has been in the position since 2017 supports her. The unit manager reports to the area manager weekly on a variety of operational issues. CHT has an overall business/strategic plan and CHT Halldene has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement.</p> <p>The unit manager has completed in excess of eight hours of professional development in the past 12 months.</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> | FA | <p>There is an organisational business/strategic plan that includes quality goals and risk management plans. The 2020 service-specific business and quality plan was in the process of development with input from staff members at the time of audit.</p> <p>All quality information is collected on an electronic data base enabling review by senior staff at head office as well as at service level. These are used to assist three monthly reviews of business and quality plans.</p> <p>Monthly staff/quality meeting minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. Meeting minutes sighted evidenced there is discussion around quality data including complaints, compliments, health and safety, accident/incident, infection control, internal audits and survey results. The staff interviewed were aware of quality data results, trends and corrective actions. Additional meetings include registered nurse meetings.</p> <p>The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies are reviewed at national level, with input from facility staff every two years. New/updated policies are sent from head office. Staff have access to manuals. Resident/relative meetings are held monthly.</p> <p>Data is collected in relation to a variety of quality activities and a comprehensive six-monthly internal audit was last completed in January 2020. Areas of non-compliance identified through quality activities are actioned for improvement.</p> <p>The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.</p> |

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| | | Residents/relatives' satisfaction surveys for 2019 continue to show high results in majority of areas (90% or higher). |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | FA | <p>The service collects incident and accident data on forms and enters them into an electronic register. The system provides reports monthly, which are discussed at the monthly staff meetings which include health and safety.</p> <p>Twelve 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 with the unit manager collects incident forms, investigates and implements corrective actions as required. Discussions with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There was appropriate notification made around a pressure injury (stage three) and three staffing issues in 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> | FA | <p>Halldene continues to implement CHT human resource management policies. A copy of practising certificates is kept. Five staff files were reviewed (two registered nurses, one activities coordinator and two healthcare assistants) and evidenced that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed.</p> <p>Current practising certificates were sighted for the registered nurses. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of rest home and hospital level care.</p> <p>The in-service education programme for 2019 has been completed and a plan for 2020 is being implemented. The unit manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Four registered nurses (including the UM and CC) of eight registered nurses, have completed interRAI training.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p> | FA | <p>Policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. Staff working on the days of the audit, were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed reported there are sufficient staff numbers.</p> <p>CHT Halldene has two care floors; each floor has a capacity of 30 residents (all beds are dual purpose rest home</p> |

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| <p>and/or experienced service providers.</p> | | <p>and hospital). As the building is new, the service is in the process of filling the new beds. At the time of audit, there were 43 residents over the two floors with the service setting staffing levels for 45 residents. Staffing continues to increase as resident numbers increase. At the time of audit, the service rostered staff on one roster and allocated groups of residents. The unit manager informed that following rosters would be by floor as numbers had increased.</p> <p>Staffing included;</p> <p>The unit manager and clinical coordinator (both practicing RNs) Monday to Friday, both of whom take a clinical leadership role.</p> <p>There are two RNs on each of the AM and PM shift and one on nights.</p> <p>Healthcare assistants rostering includes;</p> <p>AM five full shifts and two short shifts. PM four full shifts and one short shift and three on night shift.</p> <p>Staff is also added to with orientating healthcare assistants ready for the increase in rosters. There is an activity staff member seven days a week.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | <p>FA</p> | <p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual electronic medication orders with photo identification and allergy status documented on the electronic system. All medicines are stored securely when not in use.</p> <p>The service has contracted with a medical practice. This has enabled a GP to attend as well as a nurse practitioner. The nurse practitioner interviewed was satisfied that all residents are seen and reviewed in timely manner. This is an improvement from the previous audit.</p> <p>A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Medication orders include indications for use of 'as needed' medicines. Short-life medications (i.e., eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and senior healthcare assistants with medication administration responsibilities. Ten medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. A registered nurse was observed administering medications and followed correct procedures. There were no residents self-administering medicines. Fridge temperatures were recorded and room temperature recording had commenced.</p> |
| <p>Standard 1.3.13:</p> | <p>FA</p> | <p>All food is cooked on site by contracted kitchen staff. There is a food services manual in place to guide staff. A</p> |

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| <p>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>resident nutritional profile is developed for each resident on admission and is provided to the kitchen staff. The kitchen can meet the needs of residents who require special diets. Kitchen staff have completed food safety and chemical safety training. The kitchen manager and cooks follow a menu, which has been reviewed by the contracted company's dietitian. The cook (interviewed) was able to describe alternative meals offered for residents with dislikes and food is fortified for residents with weight loss. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were happy with the quality and variety of food served.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | <p>PA Moderate</p> | <p>Five resident care plans were reviewed (three hospital and two rest home). All five files included an up to date interRAI assessment. The interRAI assessments had informed the development of the resident's care plan. Care plans reviewed included; residents with falls, warfarin use, pressure area care and behaviours that challenge plus follow-up of a resident following complaints.</p> <p>Short-term care plans are in use for short-term needs. Short-term care plans are evaluated regularly, and all had documentation that the issue had resolved in a timely manner. There was documented evidence where care plans had been updated with a change of health status. Falls interventions, warfarin use and pressure area care were addressed well. Pain management and challenging behaviour were documented in the care plan but interventions not documented well.</p> <p>Residents and relatives confirmed they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Care staff interviewed reported the care plans are readily available and they found the plans easy to follow. HCAs reported that handovers were comprehensive and that they are aware of resident needs.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>FA</p> | <p>Registered nurses and HCAs follow the care plan (link 1.3.5.2). RNs report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral as evidenced in resident files. If external medical/specialist advice is required, this will be initiated by the GP. Healthcare assistants reported that they are informed of any changes to residents required needs at handover.</p> <p>Staff have access to sufficient dressing supplies. Sufficient continence products are available and resident files included a continence assessment and plan in the care plan. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, monitoring, wound management plans and short-term care plans are in place for 13 wound care plans reviewed, there were no identified pressure injuries. The RNs have access to specialist nursing wound care management advice through the district health board (DHB). Appropriate pressure injury</p> |

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| | | <p>interventions were documented in the care plans of residents identified as high risk of pressure injury and two residents with healed pressure injuries.</p> <p>Blood sugar monitoring, regular weight monitoring, turning charts and intake and fluid balance charts in use were documented.</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> | FA | <p>There are two staff employed (one a diversional therapist and one a weekend activities person) who are responsible for the planning and delivery of the individual and group activities programme with assistance from staff. There are organised activities for seven hours per day, seven days per week. CHT have also employed a supervising diversional therapist for all services who has her office at CHT Halldene.</p> <p>Group activities are provided in the communal areas, in seating areas and outdoors in the gardens when weather permits. Group activities are varied to meet the needs of both higher functioning residents and those that require more assistance.</p> <p>Individual activities are provided in resident's rooms or wherever applicable.</p> <p>On the days of the audit, residents were observed being involved with a variety of activities. The group activities programme is developed monthly and published weekly. The group programme includes residents being involved within the community with social clubs, churches and schools.</p> <p>The DT interviews each newly admitted resident on or soon after admission and takes a social history. This information is then used to develop a diversional therapy plan, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process.</p> <p>A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the residents' needs. Participation in all activities is voluntary.</p> <p>Closed chatrooms have been introduced to facilitate communication between residents and staff. Theme Days – CHT has introduced various theme days to support the activities programme. Special menus are organised, and posters, tablecloths and decorations provided to build the theme around.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p> | FA | <p>The long-term care plan is evaluated at least six monthly or earlier if there is a change in health status, using the electronic care planning system. Care plan evaluations are documented and include reporting progress on meeting goals. All changes in health status are documented and followed up. Six monthly reassessments have been completed by RNs using interRAI for all residents and for those who have had a significant change in health status. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by</p> |

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| comprehensive and timely manner. | | initiating changes to the care plan. |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | FA | <p>There is a current CPU for the building dated December 2019 for one year.</p> <p>The three-story building was fully completed at the time of audit with offices and ancillary services on the bottom floor and two care floors above.</p> <p>The organisation has purchased new equipment for the new wings. Equipment is appropriate for hospital, medical and rest home level care. Corrective actions since the partial provisional audit include; a code of compliance. All furnishings, shelving, paint, floorings, handrails and equipment have been installed to meet resident and staff needs and communal bathrooms are identifiable and privacy is ensured, hot water monitoring has been maintained and external areas have been landscaped to provide a safe and accessible outside area.</p> <p>All electrical and medical equipment is checked as part of the annual maintenance and verification checks. Equipment and medical equipment calibration and servicing is captured within the quality programme and scheduled annually.</p> <p>Policies relating to provision of equipment, furniture and amenities are documented.</p> <p>The service has sufficient equipment to meet the needs of current residents and sufficient equipment including suction and oxygen equipment, to meet the needs of medical level hospital residents.</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 emergency and disaster manual includes dealing with emergencies and disasters, essential locations, internal emergencies and external emergencies. Emergencies, first aid and CPR are included in the mandatory in-services programme and the annual training plan includes emergency training. First aid training for staff is in place with a staff member on duty at all times on level two with a current first aid certificate.</p> <p>The service has a generator on site in the event of a power failure. There is a civil defence kit for the whole facility and drinkable water is stored in large holding tanks. A civil defence folder includes procedures specific to the facility and organisation. There are walkie talkies in staff rooms on each floor to communicate between floors in the event of an emergency/fire.</p> <p>The fire evacuation plan has been approved dated 3 September 2019. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Two to four monthly fire evacuation practice documentation was sighted for the new building as part of orientation of new staff. This is an improvement from the previous partial provisional audit. There are adequate supplies in the event of a civil defence emergency including food, water and gas cooking. Short-term back-up power for emergency lighting and the call bell system is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation</p> |

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| | | <p>(CPR) is available always.</p> <p>There are call bells in the residents' rooms, and lounge/dining room areas. This is an improvement from the partial provisional audit. Residents were observed to have their call bells near. The building is secure after hours.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>Infection surveillance is described in CHTs infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the facility meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the unit manager. There have been no outbreaks since the previous audit.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were two residents with restraint and one resident with an enabler. One enabler file sampled documented that enabler use is voluntary. All necessary documentation has been completed in relation to the restraints. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff training/education on restraint/enablers has been provided as part of the annual training programme. Restraint is discussed as part of staff meetings. A registered nurse is the designated restraint coordinator.</p> |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p> | <p>PA</p> <p>Moderate</p> | <p>Care plans had been completed by registered nurses using the assessment process integrated within the electronic care planning system. Caps identified from interRAI assessments were reflected into care plans. The interventions to manage identified issues were not always documented.</p> | <p>(i) Two resident care plans (both rest home) did not reflect the management strategies to support and manage residents with behaviours that challenge/anxiety.</p> <p>(ii) One hospital care plan did not document the location, type and nursing interventions for pain.</p> | <p>(i)-(ii) Ensure that interventions are documented to support all identified risks and needs.</p> <p>90 days</p> |

Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.