

CHT Healthcare Trust - Hillcrest Hospital

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 BSI Group New Zealand Ltd, 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:	Hillcrest Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
Dates of audit:	Start date: 23 November 2020 End date: 24 November 2020
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	80



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

Hillcrest Hospital is part of the CHT group of facilities. The facility is purpose-built, providing four levels of care hospital – geriatric/medical, rest home, dementia, and residential disability – physical for up to 80 residents. On the day of audit there were 78 residents. The residents and relatives spoke positively about the care provided.

The service is managed by a unit manager who is supported by a clinical coordinator, registered nurses, and an area manager. The residents and relatives interviewed spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Service 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, relatives, management, and staff.

The shortfall identified at the previous certification audit around care planning remains an area for improvement.

Further shortfalls were identified at this audit related to the following: dignity, the quality programme, implementation of care, 24-hour activity plans for residents in the dementia unit, storage and safety of food, storage of hazardous substances, safety of outdoor areas in the dementia unit, access to call bells, proactive management or fire hazards, and environmental restraint.

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.		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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Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented, and a complaints register maintained. Complaints were described as being able to be responded to in a timely manner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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There is a business and quality plan documented. This defines the scope, direction and objectives of the service and the monitoring and reporting processes.

The unit manager provides operational oversight with support from the clinical coordinator.

There is a documented quality and risk management system in place. Policies, procedures, and forms are in use to guide practice with these now rolled out to staff. Quality outcomes data is able to be collected. Adverse events are documented.

The human resource management system is documented in policy, with recruitment completed as per policy. There is an orientation programme and annual training plan that is implemented. Staff have annual performance appraisals.

There is a clearly documented rationale for determining staff levels and staff mix to provide safe service delivery in the rest home, dementia unit and hospital. An appropriate number of skilled and experienced staff are allocated to each shift

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is a welcome pack that contains information on the services and levels of care available at CHT Hillcrest. Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. The care plans are resident, and goal orientated and updated every six months or earlier if required with input from the resident/family as appropriate. Allied health and a team approach are evident in the resident files reviewed. The general practitioner reviews residents at least three monthlies.

The activity coordinators implement the activity programme in the rest home/hospital to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are entertainers, outings, and celebrations. Activities are offered in the dementia unit.

Medications are managed appropriately in line with accepted guidelines. The registered nurses and senior health care assistants administer medications and have an annual competency assessment and receive annual education. Medication charts are reviewed three-monthly by the general practitioner.

All meals are cooked onsite by a contracted service. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Nutritional snacks are available 24 hours.

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.		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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The building has a current warrant of fitness. There is a reactive and planned maintenance programme documented. All resident rooms are single with ensuites. Each pod (of 10 beds) has a kitchenette and open plan dining and lounge area. There is sufficient space to allow the movement of residents around the facility using mobility aids. The internal areas are able to be ventilated and heated. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or other emergency. There is a first aider on duty at all times. Laundry is completed onsite.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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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 three residents with restraints in use and eight residents with an enabler. Staff receive training around restraint and challenging behaviours.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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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	10	0	2	8	0	0
Criteria	0	41	0	2	8	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available and visible at the entrance to the facility. Information about complaints is provided on admission. Interviews with residents and family confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register on VCare that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system.</p> <p>There have been six resident/relative complaints for 2020. A review of three complaints lodged in 2020 evidenced resolution of the complaints to the satisfaction of the complainants with these resolved in a timely manner. Discussion around concerns, complaints and compliments are evident in quality, clinical and staff meeting minutes. The Board is informed of any complaints identified as a medium or high risk. The unit manager has responded and met with families as required. There have not been any complaints since the last audit from external providers.</p>
<p>Standard 1.1.3: Independence, Personal Privacy,</p>	<p>PA Moderate</p>	<p>There is a policy around privacy, dignity, and respect. Staff are able to 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. Young</p>

<p>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>		<p>people with disabilities can maintain their personal, gender, sexual, cultural, religious, and spiritual identity.</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>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a range of information regarding the scope of service provided to the resident and their family on entry to the service. The information pack is available and can be read to residents who are visually impaired.</p> <p>The unit and area managers state that an interpreter would be organised for any resident or family member for whom English is a second language. Family and residents also take the pack home with the unit managers card and get family to interpret the information pack for them. The referrals come from the needs assessor with a social worker involved and the unit manager gets in touch with the social worker for support for the resident to support them to understand the pack if required. Counties Manukau at times and as per individual need, also sends a cultural support person who can be used to support the entry process for the resident and family.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Regular contact is maintained with family, including if an incident or care/health issues arises. Evidence of families being kept informed is documented in the residents' progress notes. All nine-family interviewed (five with family in the hospital, one from the dementia unit and three from the rest home) stated they were well-informed. Incident/accident documentation reviewed indicated that the next of kin are routinely contacted following an adverse event. Quarterly resident and family meetings provide a forum for residents to discuss issues or concerns.</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</p>	<p>FA</p>	<p>Hillcrest Hospital is part of the CHT group of facilities. The building is a purpose-built facility providing hospital - geriatric/medical, rest home, dementia, and residential disability (physical) level care for up to 80 residents. On the day of audit there were 80 residents. There were 55 hospital (including nine on younger persons disability (YPD) contracts); three long-term stay chronic health (LTS-CHC) and one using respite level of care; five rest home level residents (including one YPD and one LTS-CHC); and 20 in the 20 bed dementia unit (including one LTS-CHC). All other residents were under the age-related residential care services agreement.</p> <p>A CHT business plan for 2020 with a strategic theme has been developed and includes business plan targets. Hillcrest Hospital has set a number of quality goals within the unit manager performance plan and these also link to</p>

consumers.		<p>the organisation's strategic goals. The service has a philosophy of care which encompasses a resident family centred approach for younger residents.</p> <p>The unit manager has been in the role since March 2019 and was a registered nurse prior to this in aged care for 10 years. They are supported by a clinical coordinator who has been in the role for almost three years and has 19 years' experience in aged care nursing. The unit manager and clinical coordinator have completed at least eight hours of professional development. The area manager was present at the audit. They have been in this role for two years and have 10 years' experience as a registered nurse in aged care prior to the appointment.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>CHT has an established and comprehensive quality and risk programme directed by head office, based in Auckland. There are policies and procedures appropriate for service delivery including the specific needs of younger people. Policies and procedures are reviewed regularly by head office key staff who ensures they align with current good practice and meet legislative requirements. Changes to policies are communicated to staff at monthly meetings.</p> <p>Discussions with the management team and review of management and staff meeting minutes, demonstrated their involvement in quality and risk activities. A six-monthly comprehensive internal audit against the Health and Disability Standards has been completed by the area manager. Other audits including infection control, restraint and medication are also completed as per the internal audit schedule. Areas of non-compliance identified through the audit process are actioned for improvement. Three monthly quality and monthly staff and clinical meetings document staff discussions around accident/incident data, health and safety, infection control, and concerns. Minutes of meetings are posted in the staff room for all staff to read.</p> <p>The service has implemented processes to collect data, which could be utilised for service improvements. Interviews with care staff confirmed their awareness of clinical indicator trends and strategies being implemented to improve residents' outcomes.</p> <p>Residents are surveyed regularly to gather feedback on the service provided and survey results are communicated to staff, residents, and families. Corrective actions are not well documented when ratings indicate lower than anticipated results. The meeting minutes and quality plan also identified issues and concerns, however corrective action plans and/or resolution of issues was not documented.</p> <p>Health and safety policies are implemented and monitored. Health and safety inspections and hazard register reviews occur monthly and there is discussion around issues and concerns at the quarterly health and safety meeting. Adequate equipment to meet resident needs was observed to be on site including wheelchairs, walkers, hoists, and shower chairs. Equipment is checked and any repairs required are followed through to ensure repairs have been actioned.</p> <p>Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that</p>

		improvements are made. Falls management strategies include assessments after falls and individualised strategies.
<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, which are collated monthly and are discussed at the staff meetings, quality and health and safety meetings.</p> <p>Fifteen incident forms were reviewed. All incident forms identified a timely assessment of the resident completed by the registered nurse and corrective actions to minimise resident risk were documented. 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 (HCAs) interviewed could discuss the incident reporting process. The clinical coordinator collects incident forms, investigates, reviews, and implements corrective actions as required.</p> <p>The unit manager interviewed could describe situations that would require reporting to relevant authorities. The service has submitted a section 31 notification for the change in unit manager as required.</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>There are human resources policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Five staff files were reviewed (one RN, two HCAs, one clinical coordinator, and one-unit manager). All files contained relevant employment documentation including orientations. Senior (experienced) HCAs described a mentoring programme for the new, less experienced HCAs.</p> <p>The education planner documents a two-week induction programme for all staff, with additional training session over the year. Training records document that all compulsory training has been provided, with good staff attendance. Current practising certificates were sighted for the registered nurses. Registered nurses and caregivers have access to external training, which includes clinical education relevant to medical conditions such as the palliative care course. All eleven RNs (including the clinical coordinator) are interRAI competent. Staff complete competencies relevant to their roles. Staff training has included sessions on privacy/dignity, spirituality/counselling, code of rights, activities, and social media to ensure the needs of younger residents are met.</p> <p>All 14 caregivers working in the dementia unit have completed dementia units. 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>	<p>FA</p>	<p>A 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 unit manager and clinical coordinator are on duty during the day Monday to Friday. Both share the on-call requirement for clinical concerns.</p> <p>Registered nurses have sufficient time available to complete interRAI assessments and care planning evaluations within contractual timeframes. Interviews with residents and family members identified that staffing is adequate to meet the needs of residents.</p> <p>The hospital/rest home dual-purpose beds are split evenly into six wings of ten beds each (Amaryllis, Daisy, Frangipani, Hibiscus, Magnolia and Rose wings). At the time of the audit there were five rest home and 55 hospital residents across the six dual-purpose wings. The dementia (Garden) wing is separated into two, ten bed wings with a total of 20 occupied at the time of audit.</p> <p>In the hospital/rest home area there are two RNs on duty on the morning shift covering the dual-purpose beds and one RN covering the dementia unit. In the afternoon, two RNs cover the dual-purpose beds. The RNs complete each medication round in the dementia unit. On night shift one RN covers the facility. Healthcare assistants are staffed according to wings.</p> <p>Amaryllis and Daisy wings: AM two long shift HCA and one short shift; PM two long shift HCA; and night shift one HCA.</p> <p>Four other wings (Frangipani, Hibiscus, Magnolia and Rose): AM two long shift HCA and two short shift HCA; PM one long shift HCA and one floater HCA across wings; and one-night shift.</p> <p>Dementia two wings rostered as one (20 beds): AM three long-shift HCAs; PM two long shifts HCAs and one floating staff member from 3PM-7PM; two long shifts HCAs overnight.</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>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative</p>	<p>FA</p>	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are stored safely in two medication rooms (rest home/hospital and dementia unit). The service uses an electronic medication system. Registered nurses and senior HCAs are responsible for medication administration and complete annual medication competencies and annual medication education. Registered nurses have completed syringe driver competencies through the hospice. Robotic medication rolls are checked on delivery by the RN on duty. There is an impress stock and bulk supply order (for hospital level residents) which is checked weekly for expiry dates. Eyedrops are dated on opening. The medication fridge and medication rooms are checked weekly and temperatures are within acceptable ranges. There were no residents self-medicating at the time of audit.</p>

<p>requirements and safe practice guidelines.</p>		<p>Twelve medication charts on the electronic medication system were reviewed. All charts met prescribing requirements including the indication for use of 'as required' medications. All charts had photo identification and allergy status.</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>PA Moderate</p>	<p>All meals and baking are done onsite by a contracted service. Staff have completed food safety training. The four-weekly menu has been reviewed by the contracted dietitian and CHT dietitian and there is a verified food control plan expiring October 2021. The menu provides vegetarian options, soft/pureed options and accommodates ethnicities around beef and pork.</p> <p>Fortified foods (REAP) are provided for residents with identified weight loss and as instructed by the RN/dietitian. Breakfast is prepared and served by HCAs in the dining rooms of each pod of 10 beds. Meals are delivered in covered dishes in scan boxes to some of the pods and are plated and delivered on trays to other pods. There is specialised crockery and cutlery for use as required. Red plates are used in the dementia unit to assist residents at mealtimes. There are snacks available across 24/7. Resident food allergies and dislikes are known. The service uses the international colour coding to identify special diets and allergies.</p> <p>The temperatures of refrigerators, freezers and end cooked foods are monitored and recorded daily. All food is stored appropriately in the main kitchen. A cleaning schedule is maintained. Residents have the opportunity to provide feedback at resident meetings and surveys. Food stored in the unit kitchens did not meet the requirements of the food control plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>A range of residents were reviewed from across the four service levels (secure dementia unit, rest home, hospital level and younger people). Care interventions needs reviewed included (but not limited to) a respite resident, a resident who smokes, cultural needs, high falls, behaviours that challenge, choking hazard enteral feeding and pressure injury care. The interRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning process. Although, overall care plans included care needs associated with interRAI triggers, not all identified needs had been documented in the care plan and / the care interventions were not specific to the resident need. This is a repeat shortfall from the previous audit.</p> <p>The care plans for two younger people reflected individual choice including daily activities of living and interests and hobbies. Short-term care plans are in use for short-term needs including infections. Short-term care plans are evaluated regularly and either resolved or if an ongoing problem transferred to the long-term care plan. Care plans identified allied health input into the resident's care including the dietitian, podiatrist, physiotherapist, gerontology nurse specialist, specialist wound care nurse, and the mental health team.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Registered nurses (RNs) and healthcare assistants (HCAs) follow the care plan and report progress against the care plan each shift at handover. If a resident's condition changes the RNs will initiate a GP or nurse specialist referral. Relatives interviewed confirmed they were notified of any resident health changes.</p> <p>Staff have access to sufficient medical supplies and dressings. Wound assessment, wound monitoring, and wound evaluations are in place for current wounds including Three skin tears in the dementia unit, and eleven wounds for the rest home and hospital. The rest home and hospital wounds included an ulcer, skin tears, blisters, and chronic wounds. One pressure injury had healed but remained on the wound log to ensure RN oversight. Documentation and photos monitor healing progress. The wound nurse specialist has been involved with the management of the chronic wounds.</p> <p>Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available through the DHB. Bed linen availability was identified as an issue during the audit.</p> <p>There was evidence of monitoring a resident's health status such as two hourly turning charts, food and fluid charts, regular monitoring of bowels, monthly weights, blood pressure and blood sugar levels. The monitoring of behaviour and resident whereabouts were not always documented as per the care plan instruction and one resident did not have bed rail covers as per the care plan instruction.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>The service employs three activity coordinators to implement the separate rest home/hospital and dementia unit programme Monday to Sunday. Meaningful activities for residents in the dementia unit include garden walks, checking the mail, arts and crafts, baking, board games and weekly bus trips. One-on-one activities include hand massage, bible reading, sensory activities, foot spa and beauty therapy. The rest home/hospital programme include group morning activities such as exercises, newspaper reading, group strolls, arts and crafts, board games, flower arranging and storytelling. There are one-on-one activities with residents in the afternoons. The service celebrates themes, birthdays, and festive occasions. The service contracts a mobility bus for its van trips. There are community links and activities for the younger residents. These include the community gardening project, visits to town and swimming. One is doing a computer course (and has just undertaken a job interview having passed the course). The younger resident also leads many of the group exercise programmes.</p> <p>A lifestyle questionnaire is completed soon after a resident's admission. The RN completes the activity assessment on admission. An individual activities plan is developed for each resident and evaluated six-monthly by the RN, activity coordinator in consultation with the resident. The residents in the dementia unit did not have a 24-hour activity plan. Residents have the opportunity to feedback on the activity programme through resident meetings and surveys.</p> <p>Residents and relatives interviewed stated they were very satisfied with activities offered.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Initial care plans reviewed had been evaluated by the registered nurses within three weeks of admission. The long-term care plans were evaluated at least six-monthly. There is a six-monthly multidisciplinary review process that includes input from the resident (if appropriate), RN, HCAs, GP, pharmacist, physiotherapist, and any other relevant health professionals involved in the care of the resident. The family are invited to attend and are sent a copy of the review if unable to attend. The six-monthly written evaluations (on VCare) record the residents progress against the resident goals. The care plans are updated to reflect changes identified during the review (link 1.3.5.2).</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>	PA Moderate	<p>There are policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Chemicals sighted were labelled correctly and were stored safely throughout the facility. Safety datasheets are readily available. Spray paint and potting mix were not safely stored in the outdoor area in the dementia unit garden.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Moderate	<p>The building has a current building warrant of fitness that expires 9 March 2021.</p> <p>Reactive and planned maintenance is the responsibility of the property manager. Staff log any items for maintenance and repair into a maintenance book that demonstrates maintenance and repairs are addressed within a timely manner. There is a planned maintenance schedule in place for internal and external building maintenance although this had not been fully implemented. Monthly hot water temperature checks of are completed and are below 45 degrees Celsius. Essential contractors are available 24 hours. Equipment has been tested and tagged and clinical equipment calibrated.</p> <p>The facility has sufficient space and wide corridors for residents to mobilise using mobility aids and electric chairs.</p> <p>The dementia unit has an internal walking pathway and an outdoor courtyard with entry and exits doors into the building (link to 2.1.1.4 for access). The courtyard has seating and shade. Not all resident rooms were</p>

		<p>personalised.</p> <p>Care staff stated they had sufficient equipment to safely deliver the care as outlined in the resident care plans.</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>PA Moderate</p>	<p>The service has an emergency/disaster procedures manual in place. There is a staff member with a current first aid certificate on duty 24/7. Fire safety training has been provided. Fire evacuation drills have been conducted six-monthly. Fire safety has not been implemented with chemical safety, rubbish and cigarette smoking, and rubbish storage causing a significant hazard. (rectified on day of audit).</p> <p>Civil defence, first aid and pandemic/outbreak supplies are available and are checked on a regular basis. Sufficient water is stored for emergency use and alternative heating and cooking facilities (BBQ and gas bottles) are available. There is a generator available if there is a power failure. Emergency lighting is installed. The call bell system in place was not fully accessible to residents. Visitors and contractors sign in at reception when visiting. Security checks are conducted each night by staff.</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>	<p>FA</p>	<p>The infection control coordinator/RN oversees infection surveillance for the service. Surveillance is an integral part of the infection control programme and is described in CHTs infection control manual. Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends and analysis of infection events, outcomes and actions are discussed at the combined quality/health and safety and infection control meetings. Results from laboratory tests are available monthly. There have been no outbreaks since the previous audit</p> <p>Covid -19 training including PPE and outbreak management has been provided. Residents are Covid screened prior to entry to services. There are at least two weeks supply of PPE on site in the event of an outbreak.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Moderate</p>	<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 four with restraints in use (bedrails) and nine residents with enablers (seven bedrails and two lap belts).</p> <p>Resident files were reviewed for enabler use and identified the residents had given voluntary consent.</p> <p>There is a circular secure garden in the dementia unit that is able to be accessed through three doors from hallways in the dementia unit. One door is able to be opened from the inside and outside. The two other doors have pin codes on the door and require a staff member to open these. The doors are not able to be accessed from the outside if they are closed unless the resident attracts the attention of a staff member or pushes a doorbell. Staff</p>

		state that they would take any resident outside and also stated that residents would not go outside on their own. There were also hazards on the circular path e.g. stones, acorns that were slippery, branches (link 1.4.2.1)
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.3.1</p> <p>The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.</p>	<p>PA</p> <p>Moderate</p>	<p>Staff are able to describe training they have participated in around privacy, dignity, and respect. There were issues related to these principles identified during the audit. Residents and family stated that they were happy with the service and felt that they were treated with privacy, dignity, and respect.</p>	<p>Residents did not always have privacy, dignity and respect as witnessed on the days of audit. The following was identified during the audit:</p> <p>(i). The bedroom doors in the dementia unit have a glass panel in each and residents can be viewed through this even when the door is shut. One resident chooses to cover his</p>	<p>Ensure that residents are treated with dignity and respect with privacy when required around personal cares and time to self.</p> <p>60 days</p>

			<p>with a towel.</p> <p>(ii). Resident feeders at mealtimes are not always taken off in a timely manner and one resident in the dementia unit was sighted 30 minutes after they had finished the meal with a dirty feeder that had not been removed.</p> <p>(iii). Staff were heard on two occasions when in the hallway outside bedrooms in the dementia unit calling out to another staff member in the dining area asking if 'X resident was the wet or dirty one'.</p> <p>(iv). Three incidents were observed where HCAs provided care for residents using the toilet with the doors to the hallway and cubicle left wide open</p>	
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in</p>	<p>PA Low</p>	<p>The service collects data from a variety of sources including satisfaction surveys, audits, key performance indicators and complaints. There are also issues identified during meetings. The business plan includes objectives related to issues identified however there was a lack of resolution of completion of goals noted.</p>	<p>Corrective action plans with evidence of resolution are not always documented when issues are</p>	<p>Document corrective action plans with evidence of resolution</p>

<p>order to meet the specified Standard or requirements is developed and implemented.</p>		<p>The resident/relative (customer) satisfaction survey is completed monthly and reported quarterly. The March 2020 satisfaction survey showed a 96% overall satisfaction and 80% satisfaction for food services. The July satisfaction survey showed the following % satisfaction: care 89.5%; friendly staff 100%; personal attention given 75%; food 53%; activities 76.9%; cleaning 61.5%; laundry 66.7%; maintenance: 61.5%; would recommend 76.9%; overall 69.7%. The September 2020 satisfaction survey showed the following % satisfaction: care 100%; friendly staff 100%; personal attention given 50%; food 25%; activities 25%; cleaning 50%; laundry 50%; maintenance: 25%; would recommend 100%; overall 58%. While the business plan included objectives for some of these areas, there were no corrective action plans to detail a planned approach to address issues raised. Meeting minutes included discussion of some interventions to address some issues.</p> <p>Meeting minutes document issues discussed. Corrective actions or action plans are not always documented, and the issues identified in meeting minutes are always signed off as resolved on the day the issue is raised.</p>	<p>raised e.g. through satisfaction surveys and meeting minutes.</p>	<p>are not always documented</p> <p>90 days</p>
<p>Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Moderate</p>	<p>The main kitchen is spacious clean and well kept. The food control plan is up to date and documented well. The kitchen in the dementia unit and food stored in the hospital wing did not comply with the food control plan. Fridges and food stored were checked and food taken away as needed on the day of audit.</p>	<p>(i). One hospital level resident had a left-over meal stored on the shelf that had mould growing on it. (ii). The fridge in the dementia unit kitchen (that was freely accessible to residents) contained a combination of; expired food, food that had not been dated on opening and cream cheese with mould growing on it.</p>	<p>(i). Ensure that all food is safely stored according to the food control plan. (ii). Ensure that expired food is discarded, food is dated and monitored daily.</p> <p>30 days</p>

<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>All resident files reviewed included a long-term care plan and short-term care plans as needed. Care plans did not all describe specific resident needs.</p>	<p>(i). Three resident care plans in the dementia unit (two file reviews and one extra for clarification) included the need for behaviour interventions but did not include individualised and specific interventions.</p> <p>(ii). One hospital level care plan did not include the REAP program in the care plan.</p> <p>(iii). One hospital level resident did not have the recognition of pain in the care plan or mouth care interventions for a nil by mouth resident with known pain.</p> <p>(iv). One hospital level did not have management of smoking and risks in the care plan for a resident who had visible burn marks on his trousers.</p>	<p>(i). Ensure that care plan interventions are individualised and specific.</p> <p>(ii) – (iv) Ensure that care plans document the interventions to manage current care needs.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p>	<p>PA</p>	<p>The need for monitoring was identified in care plans but not always documented. The service has a large laundry on site that also provides</p>	<p>(i). One hospital level resident did not have</p>	<p>(i). Ensure that all care</p>

<p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>Moderate</p>	<p>laundry services for other CHT sites. Fresh linen is delivered each day from the onsite laundry; however, the service did not have enough fresh linen on both days of audit to ensure fresh bed linen for the beds. The issue related to lack of linen was raised in the last satisfaction survey as an issue.</p>	<p>bed rail covers in situ as per the care plan.</p> <p>(ii). Behaviour monitoring and monitoring of where abouts was not documented for two hospital residents as per the care plans.</p> <p>(iii). On both days of audit, the service did not have sufficient linen, as noted through empty linen cupboards, staff interviews and one resident in bed with no linen on the bed (a bare mattress and only blankets). The bed was also wet.</p>	<p>interventions are implemented including bed rail covers.</p> <p>(ii). Ensure all monitoring is documented according to the care plan.</p> <p>(iii). Ensure fresh bed linen is always available and residents do not sleep in wet beds with no linen.</p> <p>30 days</p>
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>There are separate group activity plans documented for the rest home' hospital and the dementia unit. Each resident has an individualised activity plan. The care plans in the dementia unit did not include a 24-hour plan.</p>	<p>Two of two resident files in the dementia unit, included an activity plan, but there were no interventions documented for all of the 24-hour period.</p>	<p>Ensure that residents in the dementia unit have a 24-hour activity plan.</p> <p>180 days</p>
<p>Criterion 1.4.1.1 Service providers</p>	<p>PA Moderate</p>	<p>There are cleaners' cupboards that store all cleaning products. The housekeepers were observed to be vigilant around ensuring the safety of</p>	<p>Spray paint cans and potting mix were</p>	<p>Ensure that all hazardous</p>

follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.		the cleaning chemicals. Not all hazardous substances were safely stored in the dementia unit. Spray paint cans and potting mix were stored on the ground and in an unlocked cupboard in the dementia garden. These were not removed immediately removed on the first day of audit despite auditors identifying these. They were still present on the second day of audit.	stored on the ground and in an unlocked cupboard in the dementia garden.	substances are stored in a safe manner in the dementia unit. 30 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Moderate	There is a documented proactive and reactive maintenance Schedule in place, however the external areas for the dementia unit were not safe for residents. The outdoor area had debris on the paths that made them slippery (e.g. acorns) and obstacles in the way such as branches and garden debris.	(i). The table and seating in the dementia garden were dirty. (ii). The walkways in the dementia garden were not clear constituting a falls hazard.	(i). Ensure that outdoor furniture is clean so that it can be used at any time by residents in the dementia unit. (ii). Ensure that the external areas are safe for residents. 30 days
Criterion 1.4.7.1 Service providers receive appropriate	PA Moderate	There are policies and procedures in place to support the safe care of residents. All essential emergency and security systems are well documented. Fire safety has not been considered by the staff in a comprehensive risk management manner. Call bells are not in place or	(i). One toilet in the hospital wing has no call bell, and one bed in the hospital wing had been moved so	(i). Ensure that all residents have access to call bells and /or can easily

<p>information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>		<p>accessible in all areas.</p>	<p>that the resident had not access to the calls bell.</p> <p>(ii). The maintenance room and the art room both had a mixture of chemicals stored on shelves with no process in place to separate incompatible flammable chemicals. Both the boiler room and the electrical switchboard room had flammable rubbish (paper and cloths covered in paint) on the floor.</p> <p>(iii). The boiler room (an internal room) was extremely hot.</p> <p>(iv). Staff routinely smoke directly outside a resident's room leaving cigarette butts and other rubbish in the ground as well as a strong smell of smoke (from cigarettes) in one bedroom.</p> <p>(v). The dementia unit had a high number of cigarette butts on the ground outside a resident's room (through the ranch</p>	<p>access assistance.</p> <p>(ii). Ensure that the risks of fire caused by hot rooms, flammable chemicals, smoking, and rubbish are fully addressed with areas where rubbish had collected being monitored at frequent intervals.</p> <p>(iii). Monitor the temperature of the boiler room and ensure that it is appropriately ventilated.</p> <p>(iv). Review the smoking cessation programme in the service for staff and ensure that staff smoke only in designated areas away</p>
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			<p>slider) and outside a door that led to the outdoor area.</p> <p>(vi). A large pile of cigarettes butts was observed on a bedside table in one resident's room (the resident was the smoker).</p>	<p>from residents (refer also to the contract that does not allow smoking by staff on the property).</p> <p>(v). Ensure that residents are offered opportunities for smoking cessation, are provided with a safe smoking area, and ensure that safe smoking practices are implemented.</p> <p>(vi). Ensure that residents are enabled to access a smoke free area with clean air.</p> <p>60 days</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the</p>	<p>PA</p> <p>Moderate</p>	<p>There is a secure outdoor area that includes garden areas and a circular path that could be accessed by residents if doors were able to be opened from the inside and out. One door is able to be accessed at any time (to the rear of the building), however two other doors from hallways into the garden area are locked with pin codes locks. Neither of the two doors with locks on them were open on the day of audit and only opened on the</p>	<p>Residents are restrained from full access to outdoor gardens and paths.</p>	<p>Ensure that residents have access to outdoor gardens and paths without</p>

needs of the consumer with the intention of promoting or maintaining consumer independence and safety.		second day when the issue of access to the garden area was raised by the auditors.		any restraint of use. 60 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.