

CHT Healthcare Trust - Peacehaven Resthome & Hospital

Introduction

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

The audit has been conducted by 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:	Peacehaven Resthome & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 15 April 2021 End date: 16 April 2021
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:	45

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

CHT Peacehaven is part of the CHT group. The service is certified to provide rest home and hospital (geriatric and medical) levels of care for up to 57 residents. All beds are certified for dual-purpose. At the time of the audit, there were 45 residents.

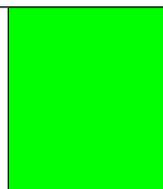
This certification audit was conducted against the relevant Health and Disability services standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents' and staff files, observations and interviews with residents, relatives, staff and management.

The unit manager is a registered nurse (RN) and maintains an annual practicing certificate. She has been in the role for five weeks. The unit manager has many years' experience in managing elderly care services prior to this role. Residents and relatives interviewed spoke positively about the service provided.

This audit did not identify any areas for improvement. The service has been awarded two continuous improvements around; health and safety and weight management.

Consumer rights

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



Standards applicable to this service fully attained.

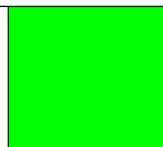
The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions.

Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Standards applicable to this service fully attained.

Services are planned, coordinated, and are appropriate to the needs of the residents. Goals are documented for the service with evidence of monthly reviews. Quality and risk data is collected, analysed and discussed, and changes made as a result of trend analysis. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education for staff is implemented and linked to competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

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.		Standards applicable to this service fully attained.
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioner and visiting allied health professionals.

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

The activities coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Policies and procedures are in place for essential, emergency and security services, with adequate supplies should a disaster occur. There is always staff on duty with a current first aid certificate.

The building holds a current warrant of fitness. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Staff regularly receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. A register is maintained by the restraint coordinator. Three residents were using enablers and no residents were using restraints at the time of the audit.

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. The infection control resource nurse (RN) is responsible for coordinating education and training for staff. The resource nurse has completed annual training provided by CHT head office. There is a suite of infection control policies and guidelines to support practice. The resource nurse uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	2	91	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Policies and procedures developed by the CHT head office are being implemented that align with the requirements of the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Families and residents are provided with information on admission which includes information about the Code. Staff receive training about resident rights at orientation and as part of the in-service programme. Interviews with three managers (one area manager, one unit manager and one clinical coordinator) and twelve staff including: four healthcare assistants (HCA), four registered nurses (RN), one cook, one housekeeper, one maintenance, one activities person) reflected their understanding of the Code with examples provided of how it is applicable to their job role and responsibilities. Five residents (four rest home and one hospital) and four relatives (two hospital and two rest home) interviewed, confirmed that staff respect their privacy and support residents in making choices.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in seven resident files (four hospital, and three rest home) were signed by the resident or their enduring power of attorney (EPOA).</p> <p>Advanced directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the resident’s file where required and activated where necessary.</p>

<p>and give informed consent.</p>		<p>Healthcare assistants (HCAs) and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Discussion with family members stated that the service actively involves them in decisions that affect their relative's lives.</p> <p>Seven resident files of long-term residents have signed admission agreements.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files included information on resident's family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are made available at reception. Information about complaints is also provided on admission. Interviews with residents and families confirmed their understanding of the complaints process. The unit manager and clinical coordinator were to describe the process around reporting complaints, which complies with requirements set forth by the Health and Disability Commissioner (HDC).</p> <p>There is a complaint register available. Eight complaints were registered in 2020 and two complaints have been lodged in 2021 (year-to-date). Five complaints were reviewed in detail (three from 2020 and two from 2021). They all reflected evidence of acknowledgement, a comprehensive investigation and communication with the complainant within the timeframes determined by HDC. Complaints received may result in a corrective action plan (quality improvement project - such as laundry services), if opportunities for improvement are identified. Staff are kept informed in meetings, evidenced in meeting minutes. All complaints received have been documented as resolved to the complainant's satisfaction, complaints are logged as 'open' until the service has completed all action plans.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and their right to make a complaint. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information is provided to them about the Code. Large print posters of the Code in English and in te reo Māori are displayed in visible locations. An RN or member of the management team discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>A tour of the premises confirmed there are areas that support personal privacy for residents. Resident rooms are large with ample room for visitors. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>Resident preferences are identified during the admission and care planning process and include family involvement. Interviews with residents and family confirmed their values and beliefs are considered. This was also evidenced in the seven residents' files reviewed. Caregivers interviewed could describe how they assist the residents to make choices.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There is a documented Māori health plan that includes recognition of Māori values and beliefs. Linkages are established to Māori advisory services. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Cultural needs are assessed during the admission process and are addressed in the care plan. There were no residents who identified as Māori at the time of the audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs. HCAs interviewed described how they have staff who speak the same Indian dialect as one resident.</p>

respect their ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. Minutes are shared with all staff. Managers provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies to guide practice that align with the health and disability services standards to meet the needs of residents requiring hospital and rest home level of care. Staffing policies include pre-employment and the requirement to attend orientation and an ongoing in-service training plan. The resident satisfaction survey reflects high levels of satisfaction with the services that are provided. The CHT mystery shopper report dated February 2021 documented 100% with regard to management services. Residents and relatives interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. The sample of adverse events reviewed met this requirement. Family interviewed confirmed they are kept informed following a change of health status of their family member or an adverse event. There is an interpreter policy in place and contact details of interpreters were available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	CHT Peacehaven is part of the CHT group. The service is certified to provide rest home and hospital (geriatric and medical) levels of care for up to 57 residents. All beds are certified for dual-purpose. At the time of the audit, there were 45 residents (11 rest home level and 34 hospital level). All residents were on the age-related residential care contract (ARRC). The unit manager is a registered nurse (RN) and maintains an annual practicing certificate. She has been in the role for five weeks. The unit manager has many years' experience in managing elderly care services prior to this role. The clinical coordinator/RN has been in the role for five years. The unit manager and clinical coordinator are supported by the area manager who was the unit manager at Peacehaven prior to the area manager role.

		<p>CHT Peacehaven has a business plan that lists performance goals for the facility that are centred on strategic themes. The unit manager reports monthly (at a minimum) to the area manager regarding progress towards meeting goals. The unit manager discussed the quality improvement themes she is implementing around: improving the resident experience, robust leadership, creating a place 'where people want to come' and health and safety.</p> <p>The unit manager has completed a minimum of eight hours of professional development in the past 12 months relating to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical coordinator is responsible for clinical operations during the temporary absence of the care manager with additional support available from the area manager.</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>The unit manager advised that she and the clinical coordinator are responsible for providing oversight of the quality programme. Interviews with the managers and staff and review of the monthly staff meetings, monthly registered nurse meetings and quarterly quality/health and safety meeting minutes confirmed that quality systems developed by CHT are being implemented.</p> <p>Data collected (eg, falls, skin tears, pressure injuries, infections) are analysed with trends identified. Results are discussed in the quarterly quality/health and safety meetings and monthly RN meeting. Minutes are posted in the staffroom for staff to read and sign. Regular staff meetings are also held which discuss operational matters. During the Covid-19 shutdown the unit manager emailed staff with updates as needed.</p> <p>A six-monthly internal audit programme is being implemented. Areas of non-compliance identified, are actioned for improvements and reflect sign-off by the area manager when completed. Additional audits include: monthly medication audits and health and safety checks.</p> <p>CHT has implemented a rolling survey with different themes sent to families and residents each month to respond to. Peacehaven has implemented this process. Survey responses were reviewed in the staff meetings and also through the complaints process (if needed). Collated response over a period of time documented that resident/family satisfaction is rated very highly.</p> <p>The service has implemented a health and safety management system. There are risk management,</p>

		<p>and health and safety policies and procedures in place including accident and hazard management. Health and safety representatives are the unit manager and clinical coordinator. Staff complete a hazard reporting form when a hazard is identified. Controls are in place to minimise hazards. Hazard controls are regularly reviewed (most recent March 2021). Contractors are orientated to health and safety processes and safety processes are very robust, resulting in a rating of continuous improvement.</p> <p>Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The unit manager or clinical coordinator investigates/signs off on all accidents and near misses. There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.</p> <p>Analyses of incident trends occur. There is a discussion of incidents/accidents in the quality/health and safety meetings.</p> <p>Seventeen incident forms that were sampled, documented clinical follow-up of residents by an RN. Neurological observations are completed when there is a suspected injury to the head. Incident form follow-up included: ongoing review through progress notes by the RN, the use of short-term care plans and pain monitoring. One resident stated that she felt very well looked after following a recent fall.</p> <p>Discussions with the unit manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no complaints involving HDC or coroner's inquests since the previous audit. One outbreak of suspected scabies was reported to public health and advice sought, all infection control procedures including isolation were implemented and four section 31s for grade three pressure injuries.</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</p>	FA	<p>Human resources policies cover recruitment, selection, orientation and staff training and development. Seven staff files reviewed (two RNs, and five healthcare assistants) reflected evidence of reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice. Orientation is specific to the individual's job role and responsibilities. Orientation programmes are also completed for volunteers (sighted in two volunteers' files).</p>

<p>requirements of legislation.</p>		<p>Current registered nursing staff and external health professionals (general practitioners, physiotherapist, pharmacists, podiatrist) practising certificates were sighted.</p> <p>There is an implemented annual education and training plan that exceeds eight hours annually per staff member. Training is primarily online with competency assessments linked to training. A register for each training session and an individual staff member record of training was verified. Additional training had included Covid-19 (infection control, PPE), pressure injury prevention, pain management, documentation, restraint, falls management, skin care, and moving and handling.</p> <p>Registered nurses are supported to maintain their professional competency. Six of the eight registered nurses have completed their interRAI training. The service encourages Careerforce qualifications for staff. There are four HCAs with level four Careerforce qualification, twelve with level three and four with level two.</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 for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. The clinical coordinator is an RN that works Monday – Friday.</p> <p>There is one roster and staff are allocated to each of the five wings, the roster allows for at least one HCA in each wing during the day plus assistance from ‘floating HCAs’ and the two registered nurses. On the day of audit there were 45 residents (11 rest home and 34 at hospital level).</p> <p>AM shift; There are two RNs and six, full shift HCAs. There is also a short shift HCA (7 am to 12 midday). PM shift; There are two RNs and five full shift HCAs. Night; There is one RN and three HCAs.</p> <p>Staff were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that the staffing levels are satisfactory and that the RNs and clinical coordinator provide good support. Residents and family members interviewed reported there are sufficient staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are held electronically and are protected from unauthorised access. Entries are computerised, dated, and include the relevant care giver or nurse including their designation. Individual resident files demonstrated service integration.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There is an implemented admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The unit manager and clinical coordinator screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines access, assessment and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The seven admission agreements reviewed meet the requirements of the ARCC and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the unit manager or clinical coordinator are available to answer any questions regarding the admission process.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. One file reviewed was of a resident who had been transferred to hospital acutely post fall. All appropriate documentation and communication had been completed. Transfer to the hospital and back to the facility post-discharge, is documented in progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were three residents self-medicating on the day of audit, all of whom had been assessed as competent to self-administer by the RN and GP. The resident's rooms were visited and confirmation that the medications were stored securely obtained. All legal requirements had been met. There are no standing orders in use. There are no vaccines stored on site.</p> <p>The facility uses an electronic medication management and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent healthcare assistants administer medications. Staff have up to date</p>

		<p>medication competencies and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridges and room temperatures are checked daily. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications electronically. Fourteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Food and laundry services are outsourced to a contractor. The kitchen unit manager oversees the procurement of the food and management of the kitchen. All meals are cooked on site. The kitchen was observed to be clean and well organised and a current approved food control plan was in evidence, expiring May 2021. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented, these included morning and afternoon teas which were served on age-appropriate china tea sets.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard, including requirements for those residents on the REAP programme. The four-weekly seasonal menu cycle is written and approved by an external dietitian. All resident/families interviewed are happy with the meals. Additional snacks are available at all times.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the resident and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been</p>

<p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>completed for all long-term residents' files reviewed. Initial interRAI assessments and reviews were evident in all resident files sampled.</p> <p>Resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint, are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident-centred. Interventions documented support needs and provide detail to guide care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the podiatrist, wound care specialist and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. The general practitioner interviewed was complimentary of the service and care provided.</p> <p>Nutrition has been considered, with fluid and fluid monitoring, regular weight monitoring and the REAP weight management system implemented where weight loss was noted. Regular weight monitoring documents over the previous fifteen months demonstrated that weight loss amongst residents had decreased, weight had stabilised, and some residents had experienced weight gain. The kitchen staff were aware of the REAP plan and this was also documented under residents' 'special diets' in the kitchen. Interventions are documented in order to guide the care staff. Care staff interviewed, stated that they found these very helpful.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included; nine chronic wounds, nine skin tears, two grade 2 pressure injuries (facility acquired) and</p>

		<p>one resident with two grade 3 DHB acquired pressure injuries. The grade 3 pressure injuries had section 31s submitted, appropriate wound care plans and specialist input.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs and wounds. All monitoring requirements including neurological observations had been documented as required.</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 is one activity coordinator covering Monday to Friday who plans and leads all activities. The service is currently recruiting for an additional activity's coordinator, so it can offer a seven day per week activities programme. Residents were observed participating in planned activities during the time of audit.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, walks outside, crafts, games, quizzes, entertainers, men's group, pet therapy, knitting group and bingo.</p> <p>The knitting group organised by the activity's coordinator is well known in the area and donates knitted products regularly to local charities including the SPCA.</p> <p>Those residents who prefer to stay in their room have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There are weekly outings and the service utilises a contracted wheelchair accessible minibus and volunteer community transport as needed. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day and Anzac Day are celebrated. There are visiting community groups such as cultural dance groups, churches and children's groups.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Residents interviewed were very positive about the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The seven resident care plans reviewed had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents which family are able to attend if they wish to do so.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The unit coordinator interviewed gave examples of where a resident's condition had changed, and the resident had been reassessed for a higher or different level of care. Discussion with the unit coordinator and registered nurses identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a building warrant of fitness which expires May 2021. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored in resident areas and are within the acceptable range. Flooring is safe and appropriate for residential care. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and decked areas are well maintained. All external areas have attractive features, including views of native bush and are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured</p>	FA	<p>All rooms have an ensuite, and there are also sufficient communal toilets and showers. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. Privacy is assured with the use of an ensuite. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Fixtures, fittings, floorings and wall coverings are in good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored</p>

privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		monthly and are within safe range as per current guidelines and legislation.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All residents' rooms are single. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are large and small communal areas. Activities occur in all areas on a rotating basis, with residents being assisted to activities in different areas if they require it. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The dining areas are spacious, inviting and appropriate for the needs of the residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All laundry is outsourced. There is a separate 'dirty' area for linen/clothing awaiting collection and a 'clean' area for deliveries. There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away in the cleaners' cupboard. All chemicals on the cleaner's trolley were labelled. Sluice rooms were kept locked when not in use.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available within the facility and include water, food and supplies (torches, radio and batteries), emergency power and barbeque. The facility keeps 3000 litres of emergency water for resident use on site. A generator is readily available on rental through a local company. There is an approved fire evacuation scheme in place and six-monthly fire drills have been completed.

		<p>A resident building register is maintained. Fire safety is completed with new staff as part of the health and safety induction and is ongoing. All shifts have a current first aider on duty.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on a display panel and also give an audible alert. Security policies and procedures are documented and implemented by staff. The buildings are secure at night. There is security lighting.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is thermostatically controlled. Staff and residents interviewed, stated that this is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well-informed about infection control practises and reporting. The infection control resource nurse is an RN who is responsible for infection control across the facility as detailed in the resource nurse job description (signed copy sighted on day of audit). The resource nurse oversees infection control for the facility, reviews incidents on the electronic resident management system and is responsible for the collation of monthly infection events and reports. CHT head office are responsible for the development of, and annual review of the infection control programme.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine. There have been no outbreaks since the last audit. The suspected Scabies outbreak was not considered an outbreak by the public health department. All infection control procedures, treatments and isolation precautions were implemented.</p> <p>Covid-19 education has been provided for all staff, including hand hygiene, donning/doffing and use of PPE.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human,</p>	FA	<p>There are adequate resources to implement the infection control programme at CHT Peacehaven. The resource nurse liaises with the infection control committee who meet regularly and as required (more frequently during Covid lockdown). Information is shared as part of staff meetings and also as</p>

<p>physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>part of the registered nurse meetings. The resource nurse has completed annual training in infection control. External resources and support are available through the CHT area manager, external specialists, microbiologist, GP, wound nurse and DHB when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by CHT head office and subject to a monthly review meeting with the area manager.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by a CHT infection control specialist.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The resource nurse is responsible for coordinating education, and ensuring staff complete the online training available on the Altura online education system. Training on infection control is included in the orientation programme. Staff have completed online infection control study in the last 12 months. The resource nurse has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is an integral part of the infection control programme and the purpose and methodology are described in the CHT surveillance policy. The infection control resource nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>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 are identified, and analysed, and preventative measures put in place. These, along with outcomes and actions are discussed at the quality/health and safety and infection control meetings. Meeting</p>

		<p>minutes are available to staff.</p> <p>Infections are entered into the electronic database (VCare) for benchmarking. Corrective actions are established where trends are identified.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. The restraint coordinator is an RN.</p> <p>There were three (hospital) residents using enablers and no residents with restraints.</p> <p>One file of one resident using an enabler (bedrails) was reviewed. Evidence of an enabler assessment and written consent by the resident was sighted. The resident's care plan reflects the use of an enabler and the enabler is monitored two-hourly. Enablers are reviewed every month.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	CI	<p>The service has a robust health and safety process lead by a group of health and safety resource staff. The group has developed a series of processes to improve health and safety education for new staff and existing staff and ensure resident (and staff) safety.</p>	<p>Peacehaven has a health and safety group who meet monthly as part of the health and safety and quality meeting. The health and safety group reviewed health and safety within the service and felt that the profile and importance of health and safety could be improved. It was found that staff had a lack of understanding and that risks were not readily understood. The group noted that new staff; many of whom were not from New Zealand, found the concept of health and safety difficult to understand.</p> <p>A new orientation booklet was developed for new and existing staff. The book is linked to a competency. The book is written in plain English accompanied with picture, photos and other learning tools to assist the staff to understand risk and their responsibilities. The book continued to be updated as a result of feedback from staff. Staff interviewed all evidenced a good knowledge of health and safety, risks and reporting.</p>

			<p>Monthly health and safety audits are documented, and issues raised are discussed at meetings. Health and safety reviews and monthly audits link directly to the services Covid response ensuring good linkages between health and safety, infection control and staff knowledge of Covid.</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	CI	<p>Unintended weight loss has reduced over the past fifteen months immediately preceding this audit.</p>	<p>Data collected and collated are used to identify areas that require improvement. Clinical indicator data has individual reference ranges for acceptable limits. Resident weights are monitored monthly with strategies implemented to reduce weight loss including: highlighting residents at risk of unintended weight loss; providing replenish energy and protein (REAP) programme training for staff; and providing a fortified food offering, allowing a higher protein and calorie content without the resident having to consume larger quantities of food and having a multidisciplinary approach to the issue which includes dietitian assessments for those residents at risk.</p> <p>Registered nurses interviewed were knowledgeable regarding preventing weight loss and those residents who were at risk. The REAP programme has been reviewed monthly and is regularly discussed at relevant meetings. Over the last 15 months (January 2020 – March 2021), of twenty residents with unintended weight loss commenced on REAP, nine had ceased to lose weight and had stabilised, seven had weight gain and four had weight loss. The four residents who continued to lose weight had medical issues that directly contributed to this.</p>

End of the report.