

CHT Healthcare Trust - Halldene Rest Home

Introduction

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

The audit has been conducted by 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:	Halldene Rest Home	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 26 January 2022	End date: 27 January 2022
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:	54	

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 Halldene is owned and operated by the CHT Healthcare Trust. The service currently provides care for up to 60 residents requiring hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 54 residents.

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

The unit manager oversees the service with the support of the area manager and clinical coordinator. Residents, relatives, and the GP interviewed spoke positively about the service provided. Improvements noted since the previous audit include the implementation of an electronic visitor management system which records the screening of visitors for COVID-19 and serves as a record of those present in the facility and those who are on day leave. An electronic data management system that allows trend analysis and benchmarking for resident incidents, falls, complaints, admissions to hospital and occupancy among others has also been introduced.

This certification audit identified the service continues to meet the Health and Disability standards.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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CHT Halldene strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is easily accessible to residents and families. Policies are implemented to support residents' rights. Informed consent processes are followed, and residents' clinical files reviewed evidenced informed consent is obtained. Staff interviews informed a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are promptly managed.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The quality and risk management programme includes service philosophy, goals, and a quality planner. The CHT management team provide support and direction to the unit manager. Quality activities are conducted, and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Resident/family meetings have been held monthly. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. An education and training programme have been implemented with an online and on-site training plan. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Resident information is appropriately stored and managed.

Continuum of service delivery

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



Standards applicable to this service fully attained.

There is an admission agreement available prior to or on entry to service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Residents' files include medical notes by the contracted geriatrician and visiting allied health professionals.

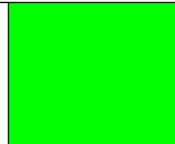
Medication policies reflect legislative requirements and guidelines. Registered nurses and senior medication competent health care assistants are responsible for the administration of medicines. Medication charts are reviewed monthly by the geriatrician.

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

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

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.

CHT Halldene a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely, and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. External garden areas are available with suitable pathways, seating and shade provided.

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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CHT Halldene has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. The service uses restraint as a last resort. On the day of audit, there were five residents with restraint and no residents with enablers. Restraint management processes are adhered to.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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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 coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and

education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. There have been no outbreaks since the previous audit.

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	50	0	0	0	0	0
Criteria	0	101	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>The policy and procedure around the Health and Disability Commissioner (HDC) Code of Health and Disability Services and Consumers' Rights (the Code) is embedded at CHT Halldene. Discussions with staff (seven healthcare assistants, four registered nurses (RN), two activities coordinators, one cleaner, one maintenance and one chef/kitchen manager) confirmed their familiarity with the Code. Interviews with three hospital level (including one YPD), two rest home residents and six family members (two rest home and four hospital level of care) confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice. Staff have received training on the Code of Health and Disability Services, Code of Rights and Employee Code of Conduct. All staff files reviewed included a signed copy of the Code of Conduct.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed</p>	FA	<p>The service has in place a policy for informed consent and general and resuscitation consents were documented on all files reviewed (two rest home and six hospital including one long term chronic care (LTS</p>

<p>choices and give informed consent.</p>		<p>CHC) and one young person with a disability (YPD) under Taikura Trust). Discussions with staff confirmed that they are familiar with the requirement to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. Three residents with dementia had activated EPOA's. One resident whose file was reviewed had an advanced directive.</p>
<p>Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance to the facility. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff, residents and relatives informed they were aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time. There are normally visiting community groups however these were restricted at the time of audit due to the Covid red alert level setting.</p>
<p>Standard 1.1.13: Complaints Management 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 in an accessible and visible location. Information about the complaints process is provided on admission. Managers (one area manager, one-unit manager and one clinical co-ordinator) and care staff interviewed were able to describe the process around reporting complaints. A complaints' register is maintained. Verbal and written complaints</p>

		<p>are documented and include any concerns identified in the resident/relative meetings and satisfaction surveys. Twenty-one complaints had been lodged in 2021, and none for 2022 (year-to-date). All complaints had a documented investigation and the outcome communicated to the complainant by letter or face-to-face meetings. Timeframes for addressing each complaint were compliant with the Health and Disability Commissioner (HDC) guidelines and corrective actions (when required) were documented.</p> <p>Complaints received and corrective actions are discussed in the monthly staff/quality meetings. Interviews with residents and relatives confirmed that they feel comfortable in bringing up concerns with the RNs and management team.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	FA	<p>There are posters of the code of rights on display throughout the facility and leaflets are available in the main entrance/reception. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the unit manager discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code of Rights and advocacy information.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage to maintain privacy and respect of personal property. All residents interviewed stated their needs were met and staff were very respectful and maintained their dignity at all times. Staff receive training around privacy and dignity and elder abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their</p>	FA	<p>There are current policies and procedures for the provision of culturally safe care for Māori residents including a Māori health plan, Tikanga best practice guidelines, cultural protocols, and consultation with Māori representatives. CHT Halldene has an established relationship with</p>

individual and cultural, values and beliefs.		the local marae (Awataha) for advice and support when required. There were no residents who identified with Māori on the day of audit. Discussions with staff confirmed that they are aware of the need to respond to cultural differences.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including residents' cultural beliefs and values, is used to develop a care plan. Staff receive training on cultural awareness and diversity and could describe how they communicate with residents of another culture. A policy describes spiritual care. Church services occurred regularly prior to Covid restrictions, while during the red alert level setting the local priest visits residents on an individual basis in their room. All residents interviewed indicated that their spiritual needs were being met when required and evaluated as part of the care plan review.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Halldene, in line with all other CHT facilities has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination free environment. The Code of Rights is included in orientation and in-service training. Training is provided as part of the staff training and education plan. Interviews with staff confirmed their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identified that they are treated fairly without any discrimination.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	The service has policies to guide practice that align with the health and disability services standards. Staffing policies cover pre-employment processes and the new employee's requirement to attend orientation and ongoing in-service training. The area manager is responsible for completing the six-monthly internal audit programme. Monthly quality

		<p>and staff meetings and monthly residents' meetings are conducted. There is a regular in-service education and training programme for staff that includes a mix of online education and inhouse in-service training. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.</p> <p>Evidence-based practice is evident, promoting and encouraging good practice. A GP visits the facility weekly. The service receives support from the local district health board (DHB). Physiotherapy services are available for six hours per week. They complete assessments on all new residents and if a resident has had a fall. A podiatrist visits every six to eight weeks. The service has links with the local community and encourages residents to remain independent. Residents and relatives interviewed spoke positively about the care and support provided.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents interviewed (as appropriate) and family members stated they were welcomed on entry and given time and explanation about the services and procedures. Fifteen accident/incidents reviewed identified the relative had been notified. This was confirmed on interview with family members. Monthly resident/relative meetings are held, and speakers attend (subject to Covid restrictions) to feedback/discuss services such as the dietitian, food service manager and laundry manager. Family newsletters are published quarterly. There are portable phones, skype available on laptops and Wi-Fi to encourage families and residents to maintain communication. There is access to interpreters as required and the service has a varied multicultural staff who can communicate in many languages.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>CHT Halldene is owned and operated by the CHT Healthcare Trust. The service provides hospital and rest home level care 60 residents. On the day of the audit, there were 54 residents in total. There were 44 hospital level residents (including one younger person with physical disabilities [YPD], and one on long term support- chronic health condition [LTS-CHC]), and ten rest home level residents. There were no residents under respite care. The remaining residents were under</p>

		<p>the age-related residential care (ARRC) contract.</p> <p>CHT has an overall business/strategic plan that includes the values and vision of the organisation: compassion, companionship, care, comfort and connected. There are area managers that report to the CEO at head office. Halldene has a unit-specific performance plan that identifies annual goals and measures such as community engagement, staff recruitment and retention, and continued Vcare implementation.</p> <p>The unit manager/registered nurse has been in the role at Halldene for seven years. She is supported by an area manager (present during the audit) and a clinical coordinator. The unit manager reports to the area manager on a variety of operational issues. The area manager usually visits the site fortnightly and has virtual meetings when Covid restrictions affect physical travel.</p> <p>The unit manager has completed in excess of eight hours of professional development in the past 12 months including attending provider cluster meetings, and aged care manager workshops (both in person and virtually).</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>	<p>FA</p>	<p>In the absence of the unit manager, the clinical coordinator is in charge, with support from the area manager, the registered nurses and healthcare assistants.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a unit business/strategic plan that includes quality goals and risk management plans. The unit manager advised that she is responsible for providing oversight of the quality programme. The quality and risk management programme is designed to monitor contractual and standards compliance.</p> <p>A document control system is in place with all quality documents reviewed on an annual basis by area managers. New policies or changes to policy are sent to the unit and communicated to staff, as evidenced in meeting minutes. Staff have access to the electronic "file vision" documents.</p>

		<p>Data is collected in relation to a variety of quality activities including adverse events, incidents/accidents, infections, restraint, medications, concerns/complaints, and internal audit outcomes. Staff interviewed confirmed they are kept informed on quality data, trends and correctives actions at the monthly combined staff/quality/health and safety meetings. Meeting minutes are made available to staff.</p> <p>The area manger completes six monthly internal audits against core standards, restraint, and infection control. Areas of non-compliance identified through quality activities are actioned for improvement. Corrective actions have been signed off when completed.</p> <p>Annual resident/relative surveys are completed, and the results fed back to participant through newsletters and resident/relative meetings. The 2021 results show an improvement in food satisfaction from 2.33 out of five to 4.5 out of five in 2020 and activities from 3.0 out of five to 4.0 out of five in the same period. The service completes monthly resident surveys (sent out to resident with birthdays in the month via head office). Action plans are developed for trends and feedback to the participant is optional.</p> <p>The service has a health and safety programme in place. There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. Health and safety is included in the combined quality/health and safety meetings. There are two health and safety representatives. One representative (interviewed) has completed stage one health and safety representative training. All new staff complete a health and safety induction including emergency situations, fire safety and safe moving and handling. Hazard identification forms are implemented. There is a current hazard register in place. All contractors complete an induction to the facility.</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 All adverse, unplanned, or untoward events are systematically</p>	<p>FA</p>	<p>Incident and accident data is collected and analysed and benchmarked through the CHT internal benchmarking programme. Fifteen resident related incident reports for December 2021 were</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>reviewed. All reports evidenced that family had been notified and appropriate clinical care was provided following an incident, including neurological observations for all unwitnessed falls. Documentation including care plan interventions for prevention of incidents, was fully documented.</p> <p>There is an accidents and incidents reporting policy. The unit manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff/quality/health and safety, clinical meetings, and handovers, including actions to minimise recurrence. Staff interviewed confirmed incident and accident data are discussed and information is made available.</p> <p>Discussions with management confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been five Section 31 notifications since the previous audit including two pressure injuries in 2021 (one facility acquired stage three and one non facility acquired stage three), one police investigation in 2020 and nine regarding RN staffing cover in July, August, and October 2021.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices including relevant checks to validate the individual's qualifications, experience, and veracity. Seven staff files (one clinical coordinator, two RNs, three healthcare assistants, including one health and safety representative, and one activity co-ordinator) reviewed, contained all relevant employment documentation and job descriptions. Current practising certificates were sighted for the RNs, and allied health professionals. All staff signed a code of conduct, code of confidentiality and information technology policy. Performance appraisals were up to date.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment.</p> <p>Staff undertake some training online via the Altura system which</p>

		<p>covers the compulsory education requirements. There are additional on-site clinical in-services and external education offered. Staff individual records of training are maintained. Staff complete competencies relevant to their role including medication, hand hygiene and safe manual handling.</p> <p>The site has one Careerforce assessor (clinical co-ordinator) to support HCAs progress through the Career force units. There are 28 HCAs, nine of which have achieved level 4, seven have level 3, four have level 2 and seven have level 1. One has enrolled and just commenced the program of study. Four of the eight RNs have completed interRAI training. Registered nurses and HCAs have the opportunity to attend aged care related study days at the district health board (DHB).</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>CHT organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The unit manager and clinical coordinator work fulltime Monday to Friday and are on call 24/7. They are supported by an area manager and registered nurses. The service is actively recruiting for one RN vacancy and HCAs to cover for periods of leave/sickness. This is now managed centrally via a recruitment specialist in CHT head office. The registered nurse on each shift is aware that staff working short shifts or float shifts can be extended to meet increased resident requirements.</p> <p>The facility is divided into six wings, three on each floor. All wings have ten rooms. Ground level consists of Puawai Bay (currently eight hospital and one rest home), Arkels Bay (six hospital and two rest home) and Fairway Bay wings (eight hospital [including one YPD] and two rest home). The first floor contains Stanmore Bay (eight hospital and one rest home), Hobbs Bay (six hospital and two rest home) and Waiau Bay wings (eight hospital and two rest home).</p> <p>There are two RNs on morning and afternoon shifts, one on each floor.</p> <p>Each floor has three full shift HCAs (07.00-15.00) and three short-shift HCAs (07.30-12.30) on the morning shift. In the afternoons there are three full shift (15.00-23.00) HCAs on each floor.</p>

		<p>On the night shift there are three full shift HCAs (23.00-07.00), one per floor with the third acting as a floater. There is one RN on night shift to cover both floors.</p> <p>Interviews with residents and relatives indicated there are sufficient staff to meet resident needs.</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>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse. Electronic records are password protected.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long term, one YPD and one LTS-CHC admission agreements sighted were signed and dated.</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>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Communication with family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The RN's and senior HCAs administer medications, all are medication competent, and competencies are up to date. There were no residents self-</p>

<p>guidelines.</p>		<p>administering on the day of audit. There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. There has been medication education this year. The medication fridge and room temperature are checked daily. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on the electronic system. Sixteen medication charts were reviewed. Medications are reviewed at least three-monthly by the geriatrician. There was photo identification and allergy status recorded. As required medications had indications for use prescribed.</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>FA</p>	<p>The food service is contracted out. There is a fulltime kitchen manager, a relief cook who works weekends and one fulltime and two part time kitchen hands. Food services staff have attended food safety training. The food control plan has been verified and expires 7 April 2022. All meals and baking are prepared and cooked on site. A dietitian has reviewed the menu. The kitchen receives a resident dietary profile and is notified of any dietary changes. Resident dislikes are accommodated. The kitchen staff were able to describe additional menu choices available for residents, (e.g., gluten free, diabetic and puree, soft and minced meals).</p> <p>Meals are transported to the dining rooms in hot boxes. Healthcare assistants assist the residents with meals. Meals are served from the hot boxes.</p> <p>Fridge, freezer, chiller, and cooked temperatures are taken and recorded daily. Perishable foods sighted in the kitchen and facility kitchenette fridges were dated. The dishwasher is checked regularly by the chemical supplier. Chemicals are stored safely. A cleaning schedule and task list is maintained.</p> <p>Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. The latest food satisfaction survey showed an increase in satisfaction</p>

		and most residents and all family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.
<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	The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	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 completed for all long-term residents whose files were sampled. Overall, the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but not limited to) nutrition, pain, and continence.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident centred. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, physiotherapist, and dietitian. The care staff interviewed advised that the care plans were easy to follow.
<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>	FA	When a resident's condition alters, the registered nurse initiates a review and if required geriatrician consultation. There was documented evidence on the communication record page that family members were notified of any changes to their relative's health status including geriatrician visits, infections, accidents/incidents, and

		<p>medications.</p> <p>Dressing supplies were sighted in the treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes and photos as applicable, were in place for all wounds. There are currently no pressure injuries.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. The RNs interviewed report they have access to the continence specialist as required through the DHB.</p> <p>Short-term care plans document appropriate interventions to manage short-term changes in health.</p> <p>Monitoring occurs for weight, vital signs, bowel records, blood sugar levels, pain, challenging behaviour, repositioning charts and food and fluid charts. These are recorded electronically.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There are four activities coordinators who work on a roster system so that weekends are covered as well. The two activities coordinators interviewed are currently completing diversional therapy training. All have current first aid certificates. On the days of audit rest home and hospital residents were observed doing exercises, listening to music, and doing craft. Residents who attend activities enjoy them and families are satisfied.</p> <p>There is a weekly programme in large print on noticeboards and residents may have a copy in their rooms if requested. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one on one visits to check if there is anything they need and to have a chat.</p> <p>There are monthly interdenominational church services. A Catholic priest visits to give communion.</p>

		<p>Residents have the opportunity to go for a drive or may have a picnic on the monthly van outings. Special events such as birthdays, Matariki, Easter, Anzac Day, and Queens's birthday are recognised and celebrated. There is community input from entertainers, choirs, and Kapa Haka groups. The Whangaparoa library brings books and other resources for residents to borrow. All visitors and entertainers must show evidence of vaccine status and wear masks in line with current covid guidelines. Prior to covid19 restrictions children from preschools and local schools visited the facility. There is a fortnightly visit to a lunch club as restrictions allow.</p> <p>[Redacted]</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career, and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. Resident meetings are held monthly.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Except for recent admissions resident care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. Short- term care plans for short- term needs are evaluated and signed off as resolved or added to the long- term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, geriatrician, and resident/family if they wish to attend. There are three monthly reviews by the geriatrician for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.</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</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been</p>

<p>to meet consumer choice/needs.</p>		<p>referred to the dietitian, physiotherapist, hospice, and hospital specialists. Discussion with the registered nurse identified that the service has access to a wide range of support either through the geriatrician, 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>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. A sharps container is available and meets the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, masks, and goggles are available for staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The service displays a current building warrant of fitness (21 June 2022). Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested, tagged, and calibrated. The maintenance person is shared between three facilities and he is on call if required. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn, and gardens. Healthcare assistants interviewed confirmed there is adequate equipment to carry out the cares, according to the resident needs, as identified in the care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Twelve rooms have toilets and hand basins. The rest all have ensembles. There are sufficient communal toilets and showers. Fixtures, fittings, and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs if required. There are signs on all shower/toilet doors.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All rooms are single. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are two levels each with three wings. Each wing has ten residents. Each wing has a communal lounge/dining room and a kitchenette where residents/visitors can make a cup of tea/coffee. There are comfortable chairs for residents to relax in. Activities take place in the lounges. The top floor has beautiful sea views and both floors have views of a park. There is a lift between floor, which is large enough to take a bed/stretcher.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is done off site by external contractors. The laundry is dropped off and picked up daily. There are ample supplies of linen. There is a small laundry area where personal laundry may be done if wished.</p> <p>There is a sluice room with a sanitiser on each level for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice rooms and the laundry are locked when not in use.</p> <p>The cleaner is employed by the facility and CHT ensure infection control and chemical safety training is completed. Cleaning trolleys have a locked box where chemicals are stored. When not in use cleaning trolleys are stored in a locked cupboard. Cleaning and laundry services are monitored through the internal audit schedule.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The fire evacuation plan has been approved by the fire service 3 October 2018. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation drills occur, with the most recent on 20 January 2022. Fire training and security situations are part of</p>

		<p>orientation of new staff and ongoing as part of the annual planner.</p> <p>There are adequate supplies in the event of a civil defence emergency including food and gas cooking. There are 4000 litres of potable water held in external tanks that are automatically activated in an emergency. There is emergency lighting and an emergency diesel generator available on site.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The building is secure after hours with all external doors linked to the alarm system.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <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. There is underfloor heating. There is a smoking area outside.</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 prevention and control programme is appropriate for the size and complexity of the service. An infection control coordinator (RN) is responsible for infection control across the facility, who is assisted by the unit manager if required. A job description has been signed which outlines the role and responsibilities. The infection control coordinator provides monthly reports to head office, the manager and to RN and staff meetings.</p> <p>The programme is documented and reviewed annually from head office and directed via the quality programme.</p> <p>All visitors and contractors are required to sign in, wear a mask and have vaccination passes checked. All staff and most residents have Covid vaccinations and boosters. Residents and staff are offered the annual influenza vaccine. There are adequate hand sanitisers and signage throughout the facility. There is an outbreak management cupboard and an ample stock of personal protective equipment that is checked weekly. More personal protective equipment (PPE) can be</p>

		obtained from a CHT central storage area if required.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator has completed online DHB and CHT infection control education. This is updated annually. During Covid19 there has been regular information from head office.</p> <p>The facility has access to an infection control nurse specialist through the DHB, public health, GP's, local laboratory, and expertise from within the CHT company.</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>	FA	<p>There are comprehensive infection control policies that are current and reflect standards, legislation, and good practice. These policies are developed by head office and reviewed annually. There is resource information and plans around Covid19 from head office and from the facility.</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>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Training is provided at orientation and as part of the annual training schedule. All staff complete hand hygiene audits. Inservice has been provided around personal protective equipment (PPE) and outbreak management and there has been particular emphasis on this since Covid19. Any new communication re Covid19 is relayed to staff re meetings, noticeboards and at handovers. Resident education occurs as part of providing daily cares.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Infection control statistics are benchmarked with other CHT facilities. Corrective actions are implemented where infections are</p>

		<p>above the benchmark. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the geriatrician and laboratory that advise and provide feedback/information to the service.</p> <p>Infection control surveillance data is shared with all staff at meetings and on noticeboards.</p> <p>The service has process and procedures implemented to manage the risk posed by Covid -19. Additional education has been provided around personal protective equipment (PPE) and all staff have attended. Information is regularly updated and shared. The latest information posted is concerning Omicron. All residents are screened prior to admission. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. The service has five residents using restraint (bedrails) and no residents using enablers. All necessary documentation has been completed in relation to the five restraints. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS8134.0. Staff receive training/education on restraint/enablers and restraint is discussed as part of the staff/quality/health & safety and clinical staff meetings.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The clinical co-ordinator (registered nurse) is the restraint coordinator. The assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident, or representative and medical practitioner. The restraint team monitors and checks all restraints at least monthly.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in the five resident's files reviewed who were using</p>

		restraint. The restraint coordinator, registered nurse, the resident and/or their representative/EPOA were involved in the assessment and consent process, along with medical practitioner input. In the files reviewed, assessments and consents were fully completed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified, and approval processes are obtained/met. An assessment form is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular monitoring at the frequency determined by the risk level were present in the restraints reviewed. The service has a restraint and enablers register, which is updated each month and a report forwarded to the staff/quality/health and safety meeting.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every six months. In the files reviewed, evaluation of restraint use had been completed with the resident, family/whānau and restraint coordinator in conjunction with the six-monthly care plan evaluation. The restraint use is reviewed monthly by the restraint coordinator.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. The restraint coordinator and unit manager complete the restraint review. Any adverse outcomes are reported at the monthly combined, staff/quality and health & safety meetings.

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, 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.