

# CHT Healthcare Trust - CHT Bernadette

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## 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:** CHT Bernadette

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 20 January 2022      End date: 21 January 2022

**Proposed changes to current services (if any):** A further 23 rooms were verified as suitable as dual-purpose beds. Which resulted following stage two of the rebuild and refurbishment (2019). Total beds numbers were increased from 69 beds to 92 beds.

**Total beds occupied across all premises included in the audit on the first day of the audit: 87**



# Executive summary of the audit

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## 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 Bernadette is owned and operated by the CHT Healthcare Trust and cares for up to 92 residents requiring rest home or hospital (geriatric and medical) level care.

On the day of the audit, there were 87 residents. The service is overseen by a unit manager who is well qualified and experienced for the role and is supported by a clinical coordinator and the area manager. Residents, relatives, and the GP interviewed spoke positively about the service provided.

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

This audit has identified areas for improvement around: complaints management, discussion around corrective actions, safe storage and handling of chemicals and the call bell system.

## Consumer rights

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

Some standards applicable to this service partially attained and of low risk.

Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. 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 in line with the facility's Covid 19 response framework.

There is a policy around management of complaints documented. Residents and relatives were aware of the complaint process and where to access complaint forms.

## Organisational management

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

Some standards applicable to this service partially attained and of low risk.

Services are planned, coordinated, and are appropriate to the needs of the residents. The unit manager is responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is documented. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme specific to the role is in place for new staff. Ongoing education and training for staff includes in-service and online education and training. Registered nursing cover is provided seven days a week, twenty-four hours a day. Residents and families report that staffing levels are adequate to meet the needs of the residents. The integrated electronic 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 (GP), 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 (Medimap) 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.

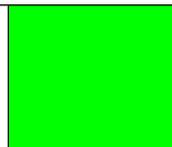
## Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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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. An external contractor manages the cleaning and laundry services. 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.

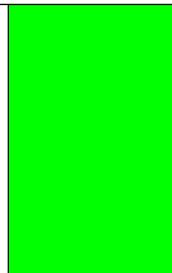


Standards applicable to this service fully attained.

The restraint coordinator is the clinical coordinator. The service had four residents assessed as requiring the use of restraint and one resident assessed as requiring an enabler. Staff regularly receive education and training in challenging behaviour and restraint minimisation and safe practice. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## 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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform service providers.

Documentation evidence that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events.

Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. The organisation benchmark internally with their other facilities.

## 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	46	0	2	2	0	0
Criteria	0	97	0	2	2	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 Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with one regional manager and eighteen staff (six healthcare assistants, six registered nurses (RNs), one activities coordinator, three kitchen staff [one lead chef], one weekend chef and one maintenance) confirmed their familiarity with the Code and its application to their job role and responsibilities. Interviews with six residents (five hospital level including two young persons with disability (YPD) and one rest home level) and four relatives (one rest home level and three hospital level confirmed that the services being provided are in line with the Code. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>Ten of ten resident electronic records sampled (five from the rest home and five from the hospital) have a signed admission agreement and completed informed consent documentation including for the flu</p>

informed consent.		vaccine and Covid vaccine.
<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>	FA	<p>A policy describes access to advocacy services and staff receive regular training on advocacy. Information about accessing advocacy services information is available in the information presented to residents and families at the time of entry to the service. Advocacy contact details are included on complaint forms and in complaint resolution letters. Advocate support is available if requested. Interviews with staff and residents confirmed that they are aware of the resident's right to advocacy services. Healthcare assistants interviewed confirmed that they help advocate for the residents.</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>	FA	<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 and family members interviewed confirmed that the service made an effort to maintain contact with relative/family members when visiting could not occur during certain times of the Covid-19 response framework. Community links were evident within the examples provided. Residents are assisted to maximise their potential for self-help and to maintain links with whānau and the community by supporting them to go out into the community. The younger people with a disability (YPD) choose activities they wish to participate in (if able). The activities programme includes entertainers and volunteers (when permitted). Interview with two younger persons with disabilities confirm they are encouraged to maintain their community links and normal routine.</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>	PA Low	<p>The service has a complaints policy that describes the management of the complaints process. There are complaints forms available at reception that provide links to the health and disability commission (HDC) advocacy services. Information about complaints is provided on admission. Interviews with residents and families demonstrated an understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register that is held by the unit manager. Ten complaints were recorded (four for 2020 and six for 2021), there were no complaints received year to date for 2022. Verbal and written complaints are documented in the electronic system. All complaints (except two) reviewed had noted investigation, timeframes, corrective actions when required and were signed off as resolved. Not all results are fed back to complainants in a timely manner. Complaints are trended at head office.</p> <p>The HDC had requested information regarding a coroner's inquest in relation to another service provider. The requested information has been sent, and no further action has been required at the time of the</p>

		<p>audit.</p> <p>Discussions with residents and families confirmed they understand the complaints process.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters of the Code on display and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss.</p> <p>On entry to the service, the unit manager discusses the information pack with the resident and the family/whānau. The resident pack includes a summary of information relating to the Code and a pamphlet on the Code.</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>Policies 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 maintaining privacy and respect of personal property. All residents interviewed stated their privacy needs were met and that they were treated with dignity and respect. The area manager is the privacy officer.</p> <p>Staff receive regular training around recognising abuse and neglect (July 2021). There have been no reported incidents of abuse or neglect since the last audit.</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>The service has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and involvement is encouraged. The service has links with the local Māori iwi for advice and support as required. There were two residents and two staff who identified as Māori at the time of the audit. Cultural needs were addressed in the residents' care plan and recognise the effect of any decision on the resident's relationship with their family, whānau, hapū, iwi, and family group and their links to whakapapa to be considered.</p> <p>Staff completes annual cultural awareness education. The service has established cultural policies to help meet the cultural needs of its residents.</p> <p>The principles of the Treaty of Waitangi are incorporated into day-to-day practice. There is a specific current Māori health plan and all values and beliefs that the resident holds are acknowledged with the support of the Te Whare Tapa Wha model with support from cultural advisers within the local community available as required. The resident and family were unavailable to be interviewed at the time of audit.</p>

		<p>Māori links are established through the DHB.</p> <p>Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. Discussions with staff confirmed that they are aware of the need to respond to cultural differences and the importance. One resident and one staff member interviewed confirm their beliefs, values and practice are respected.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>There is a policy that describes spiritual care. Monthly church services are conducted in the facility. Residents interviewed confirmed that their spiritual needs were being met. 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 each resident's cultural beliefs and values, are used to help to develop a plan of care. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility has a staff code of conduct that staff sign as part of the employment process. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, code of conduct and professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that aligns with the Health and Disability Services Standards, for residents with aged care and residential disability needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents and families interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care.</p> <p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, physiotherapist, hospice/palliative care team, district nurse, wound care specialist, mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own</p>

		<p>professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the knocking on doors before entering a room, day to day discussions with residents and their families and staff interviewed being able to identify that they know the residents well.</p> <p>The quality programme includes a collation of several clinical indicator data to identify opportunities to improve care services to their residents. A comprehensive handover process promotes continuity of care delivery.</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>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay for that is not covered by the agreement. The information pack is available in large print and in other languages. It is read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Regular contact is maintained with family including if an incident or care/health issues arise. Evidence of families being kept informed is documented on the electronic database and in the residents' progress notes. Fifteen incident/accident forms and corresponding residents' files were reviewed, and all identified that the next of kin were contacted in a timely manner after adverse events or at any time the residents deteriorate. Regular resident and family meetings provide a forum for residents to discuss issues or concerns. Access to interpreter services is available if needed, for residents who are unable to speak or understand English. Staff completed training in communicating effectively with residents with cognitive deficits and /or speech impediments (June 2021). Communication to families related to Covid-19 is published on the website, regular newsletters and individual emails are sent to relatives. Family members interviewed confirm they are updated with any changes in health of their relative and feel informed about the facility's strategy under the Covid 19 preparedness framework.</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 Bernadette is owned and operated by the CHT Healthcare Trust. The service provides hospital and rest home level care for up to 92 residents. On the day of the audit, there were 87 residents. This included 42 rest home level residents and 45 hospital level residents. One resident (hospital level) was funded by ACC, four residents (hospital level) was on the young person with a disability (YPD) contract, and three residents were on the long-term service chronic health care (LTS-CHC) contract (two hospital and one rest home).</p>

		<p>A further 23 rooms were verified as suitable as dual-purpose beds. Which resulted following stage two of the rebuild and refurbishment (2019). Total beds numbers were increased from 69 beds to 92 beds.</p> <p>All rooms that are currently being used on two levels are certified dual purpose, including two double rooms (currently with single occupancy) in the Papamoa wing.</p> <p>The organisation has a philosophy of care, which includes a mission statement. An annual business plan is in place which links with quality goals is implemented and reviewed on a regular basis. The plan has a focus on Covid 19 business preparedness, and the risks associated, and on the current workforce issues. Goals included around recruitment and retention of staff and overall business contingency plan including health and safety.</p> <p>The unit manager is a registered nurse and been three years in the role. She has 20 years of experience in aged care, maintains an annual practicing certificate and regularly attended CHT management training.</p> <p>The clinical coordinator is a registered nurse who was appointed to her role since November 2021 but has been with CHT since 2015. She is trained in interRAI and regularly attends in-service training. Her medication competencies (including syringe driver) were up to date.</p> <p>The unit manager reports weekly to the area manager on a variety of operational issues. The unit manager has completed in excess of eight hours of professional development in the past 12 months.</p>
<p><b>Standard 1.2.2: Service Management</b></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>In the absence of the unit manager, the area manager is in charge with support from the clinical coordinator, care staff and head office.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk</p>	PA Low	<p>The performance plan for the facility includes quality goals (strategic themes) with associated actions, milestones and dates achieved. The unit manager advised that she is responsible for providing oversight of the quality programme. Interviews with staff confirmed their familiarity with the quality and risk management systems that have been put into place.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that</p>

<p>management system that reflects continuous quality improvement principles.</p>		<p>the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed and updated at the organisational level. New policies or changes to policy are communicated to staff in the staff meetings.</p> <p>A range of data including; falls, incidents, property incidents, complaints, staff incidents, complaints, restraint, and medication errors are collected, collated and analysed at head office. The area manager and the unit manager advised the results are shared with staff. An internal audit programme consists of two six-monthly audits completed by the area manager (March and October 2021). There was evidence in the staff meetings to verify staff were informed of the internal audit results. Other audits include a monthly health and safety internal audit, and resident satisfaction surveys are regularly sent to residents and family. Other internal audits include monthly restraint audits, weekly wound and skin audits and monthly health and safety inspections.</p> <p>The 2021 meeting minutes were reviewed. Interviews with staff confirmed that meeting minutes are posted for them to read/review. Resident/family meetings take place on a quarterly basis.</p> <p>Although corrective actions were identified and signed off following the six-monthly internal audits the corrective actions recorded that were identified during meetings (quality, staff, and resident meetings) were not always addressed, follow up or signed off. The complaints process was not followed for two complaints (link 1.1.13.3).</p> <p>A health and safety programme is in place that meets current legislative requirements. The clinical coordinator is the designated health and safety officer and has completed formal training in hazard identification and management. An interview with the health and safety officer (clinical coordinator) and review of health and safety documentation confirmed that legislative requirements are being upheld. External contractors and all new staff have been orientated to the facility's health and safety programme including Covid 19 preparedness requirements. The hazard register was up to date and is reviewed quarterly by the health and safety committee. Hazardous substance register is in place.</p> <p>Strategies are in place to reduce the number of residents' falls. All new residents and residents who have experienced a fall are assessed by a physiotherapist (works 6 hours weekly). Sensor (buzzer) mats are used for those residents who are at risk of falling. These residents are checked frequently and are encouraged to be out of their rooms during the day so that they can be monitored more closely.</p>
<p>Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy that is being implemented by the service.</p> <p>Fifteen accident/incident forms were randomly selected for review. A registered nurse conducts clinical follow up of each adverse event. Neurological observations are conducted for unwitnessed falls. All adverse events reviewed demonstrated that appropriate clinical follow up and investigation took place.</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>Adverse events are also reviewed and signed off by the unit manager.</p> <p>Trends are identified at head office with data benchmarked against the other CHT facilities. This data is available electronically for managers to access, which is discussed at facility meetings.</p> <p>Discussion with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications with examples provided (e.g., police investigations, RN cover, pressure injuries). There were nine section 31 reported to HealthCERT including one coroner investigation, six for RN unavailability for July-August 2021, one for a missing resident, one non-facility acquired unstageable pressure injury.</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 resource management policies in place that include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience, and veracity. Copies of current practising certificates are retained. Eight staff files (clinical coordinator, three RNs, three HCAs and one activities coordinator) reviewed evidenced implementation of the recruitment process, employment contracts and annual performance appraisals.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and remarked that new staff were orientated to the service. Evidence of an orientation programme being completed was sighted in the staff files reviewed of staff who had been hired by CHT.</p> <p>There is an annual education plan that is being implemented that includes in-services and completion of online education modules. The competency programme is ongoing with different requirements according to work type. The unit manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Four of the ten (including clinical coordinator) registered nurses employed have completed interRAI training.</p> <p>The unit manager completed attended monthly CHT manager's meetings and attended professional development relating to managing an aged care service. In addition, she attends in-service training at the facility (e.g., chemical safety, syringe driving training, restraint minimisation, cultural training, infection control training, food safety training). The clinical coordinator has maintained training records that reflect attendance at the following in-services in 2021: informed consent; abuse and neglect; cultural safety; medication management; death and dying; infection control; clinical emergencies/CPR; continence management; restraint minimisation; skin and wound management; health and safety; chemical handling; and accident/incident reporting.</p> <p>There are 49 HCAs with 27 completed level four and seven have completed level 3 National certificate in Health and Wellbeing and six at level two. The area manager confirmed several HCAs are enrolled at</p>

		different levels with Careerforce.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>CHT policy includes staff rationale and skill mix. There were 87 residents at the facility at the time of the audit. The service regularly uses agency RNs.</p> <p>Sufficient staff are rostered on to manage the care requirements of the residents. The area manager confirmed that there is now a full complement of RNs on the roster. The roster reviewed confirmed all shifts are covered and where required agency RNs are booked to complete the roster. Agency staff are used when casual staff are not available. The unit manager remarked that RN staffing turnover has been moderate with losses reported in 2021 to the DHB. There is a clearly documented process to manage risk in case of RN unavailability this include RN to extend shifts and work 12-hour days, or the shifts will be covered by the unit manager and clinical coordinator when all other options fail. The service currently recruiting to fill 60 hours per month of various HCA shifts on the roster and 45 hours to extend the activities.</p> <p>The unit manager and clinical coordinator support the RNs Monday – Friday.</p> <p>Maua (upstairs) 25 beds (9 Rest home and 16 Hospital were occupied)</p> <p>AM: RN 7am-3pm, 2 HCAs from 7-3pm, one HCA from 7am-12am and one from 8am-1pm.</p> <p>PM: 2 HCAs from 3pm-11pm; one HCA 3pm-8pm (medication competent).</p> <p>Rest home residents' upstairs are very independent.</p> <p>Pilot 25 beds (15 Rest home and 9 Hospital were occupied).</p> <p>AM: RN 7am-3pm; 2 HCAs from 7-3pm and one HCA from 7am-12am.</p> <p>PM: RN 3pm-11pm; 2 HCAs from 3pm-11pm.</p> <p>(Bayfair, Welcome Bay) 23 beds (10 Rest home and 12 Hospital were occupied).</p> <p>AM: 2 HCAs from 7am-3pm and one floater 7am-12am.</p> <p>PM: RN 3pm-11pm and 2 HCAs from 3pm-11pm (also oversee Omanu/Papamoa).</p> <p>Omanu/Papamoa 19 beds (8 Rest home and 8 Hospital were occupied).</p>

		<p>AM: 2 HCAs from 7am-3pm and floater 7am-12am (the floater shifts are regularly extended or change to 10am-3pm).</p> <p>PM: 1 HCA from 3pm-11pm and one from 4pm-9pm.</p> <p>*There is a regular agency HCA for a 10am-3pm shift to work across wherever they needed.</p> <p>Night:</p> <p>RN: 10.45pm-07.15am</p> <p>5 HCAs from 11pm-7am</p> <p>Activities: Monday- Thursday two from 10am-3pm and one 10am-2pm and Friday- Sundays two from 10am-3pm</p> <p>An external contractor employs the laundry and cleaning staff.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</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 electronic record supplemented by a resident file. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public are not able to view sensitive resident information. Entries in records are legible, dated and signed by the relevant HCA or RN. Documents are archived on site in an appropriate secure room.</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 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 Related Residential Care Agreement (ARRC). The ten admission agreements reviewed meet the requirements of the ARRC and were signed and dated. Exclusions from the service are included in the</p>

		<p>admission agreement.</p> <p>Family members and residents interviewed state that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members report 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>	FA	<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>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-medicating on the day of audit, and 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. Registered nurses and senior medication competent health care assistants administer medications. Staff have up to date 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 and were within safe limits. Eye drops and topical medications were dated once opened.</p> <p>Staff sign for the administration of medications electronically. Twenty 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 and effectiveness post administration documented.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food,</p>	FA	<p>Food services are outsourced to an external contractor. The chef 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,</p>

<p>fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>expiring 7 February 2022. All kitchen staff have food safety and hand hygiene training. Special equipment such as lipped plates are available. On the day of audit, meals were observed to be well presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Kitchen fridge and freezer temperatures are monitored and recorded daily. Meals are served in each area from hot boxes. Food temperatures are checked at all meals and these were all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements, 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 (replenish and energy protein) programme. The four-weekly seasonal menu cycle is written and approved by an external dietitian. Audits are implemented to monitor performance. Residents and families interviewed had variable comments regarding the standard of meals (link 1.2.3.8). The satisfaction survey score completed in January 2021 was 3.0 out of five which improved to 3.5 in May 2021 at the re-audit.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whanau 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> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents' files reviewed. Initial interRAI assessments and reviews are evident for all resident files sampled.</p> <p>Resident files reviewed identify 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 were resident centred. Interventions documented support needs and provided 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>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 six chronic wounds, seven skin tears, one grade 1 and one grade 2 pressure injuries (facility acquired) and one resident with an unstageable pressure injury. The unstageable pressure injury had a section 31 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>	<p>FA</p>	<p>There is one activity coordinator covering Monday to Saturday and alternate Monday to Sunday (with one weekday off) who plans and leads all activities. The service is just recruited an additional activities coordinator and fills in gaps with agency staff as required. 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>Those residents who prefer to stay in their room have one-on-one visits to check if there is anything they need and to have a chat.</p>

		<p>There are outings three times per week and the service utilises a contracted wheelchair accessible minibus. There are regular entertainers visiting the facility when Covid restrictions permit. 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 (again, subject to Covid level restrictions). The library bus visits the facility. The facility has a cat and there is pet therapy twice weekly.</p> <p>The YPD residents have individualised activity plans that take account of their age, culture, and abilities. They are encouraged to maintain links with the local community and are supported with the use of their own phones, laptops, and tablets to have regular contact with friends and family. Activities observed include age-appropriate music and film choices.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, which 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>Resident meetings are held three-monthly. Residents interviewed commented positively about the activity programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The seven of the ten resident care plans reviewed had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status (three had not been in the service for 6 months). 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. Care plan reviews evidence resident progression towards meeting goals. 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) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other 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 and registered nurses interviewed could give 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 identifies 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>	<p>PA Moderate</p>	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets for chemicals are readily accessible for staff. Not all chemicals are stored in locked areas throughout the facility and staff were seen to be using chemical from unlabelled and/or mis-labelled containers. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit.</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 building holds a building warrant of fitness which expires 22 April 2022. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>A further 23 rooms were verified as suitable as dual-purpose beds. Which resulted following stage two of the rebuild and refurbishment (2019). Total beds numbers were increased from 69 beds to 92 beds. (Welcome Bay has 11 beds and Bayfair wing has 12 beds). They are built around a courtyard, . All rooms have full shower ensuites, apart from those standard rooms in Welcome Bay wing which have ensuite toilets and shared communal shower facilities. There is a lounge in each wing and a nurses station and treatment room in Welcome Bay.</p> <p>The facility provides rest home and hospital level of care for up to 92 residents in dual purpose beds. There are two levels to the building and include 25 beds (Maua wing) upstairs with a nurse's station, sluice, lounge, dining room and courtyard.</p> <p>The remainder of the beds are downstairs (Bayfair, Welcome Bay, Pilot, Papamoa and Omanu). There is a lift spacious enough to accommodate ambulance transfer equipment and stairs. There are two nurse's stations downstairs (one in Pilot wing and one in Welcome Bay). The kitchen, laundry area and hairdresser salon are located downstairs. Sluices are located centrally.</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 courtyard areas (including one courtyard upstairs) are well maintained. All external areas have attractive features, including raised beds and planters. 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 privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All rooms have full shower ensuites, apart from those standard rooms in Welcome Bay wing which have ensuite toilets and share communal shower facilities. There are 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 ensuites. Communal toilet/shower facilities have a system that indicates if it is engaged or vacant. Fixtures, fittings, floorings, and wall coverings are good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation.</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>	FA	<p>All resident's rooms are single apart from two doubles (these are currently used for single occupation in Papamoa wing). 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.</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>	FA	<p>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.</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>	FA	<p>Personal clothing and laundry are taken off site and laundered by a contracted company. When the laundry is returned to site the caregivers sort the personal clothing and take it to the residents' rooms. There is a defined clean and dirty area of the laundry and an entry and exit door. The laundry area is well equipped. Personal protective clothing is available including gloves, aprons, and face masks. Adequate linen supplies were sighted.</p> <p>Cleaners are available seven days per week. Cleaning staff could adequately describe their responsibilities and procedures related to infection prevention and control. 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 while in use, and lockable storage was available for</p>

		chemicals in the cleaners' cupboard (link 1.4.1.1).
<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>	PA Moderate	<p>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 a 2000 litre tank of emergency water for resident use on site, plus a store of readily accessible bottled water within resident areas. A site has its own generator which is capable of fully powering the facility should this be required in an emergency situation.</p> <p>There is an approved fire evacuation scheme in place (dated 23 March 2021) and six-monthly fire drills have been completed. A resident evacuation 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 are designed to show on a display panel and also give an audible alert. However, a recent upgrade of the call bell system has resulted in technical issues affecting the safe operation of some call bells. 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</p>	FA	<p>CHT Bernadette has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service, which is linked into the incident reporting system. A registered nurse is the designated infection control coordinator who has a signed job description in place which outlines the role and responsibilities. The infection control coordinator has support from the unit manager, the clinical coordinator and staff involved in the infection control meetings. Infection control is linked to clinical, staff and quality meetings. Spot audits have been conducted and include hand hygiene and infection control practices. Education is</p>

<p>appropriate to the size and scope of the service.</p>		<p>provided for all new staff on orientation. The infection control programme has been reviewed annually. Resident education occurs during cares or opportunities at resident meetings. Visitors are reminded not to visit if they are feeling unwell</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control (IC) coordinator has good external support from the local laboratory, an external contractor, infection control team and IC nurse specialist at the DHB and CHT head office. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p> <p>Staff were observed to practice good handwashing techniques. There are sufficient stock including isolation kits, masks, and other personal protective equipment (PPE). Staff interviewed confirm they adhere to cleaning practices for equipment use between residents, reusable items but also touch screens and computer equipment.</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>There are CHT infection control policies and procedures appropriate for the size and complexity of the service. Policies are available electronically on file vision or in hard copy, which have been reviewed and updated. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. Policies include information and a response framework on Covid 19 preparedness including cleaning and laundry practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers,</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed external infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and</p>

support staff, and consumers.		visitors that is appropriate to their needs and this is documented in medical records.  Staff completed competencies for handwashing and the correct use of PPE. Toolbox meetings and scheduled training related to the facility's Covid19 preparedness.
Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance is an integral part of the infection control programme and is described in CHT's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered into an electronic resident system and extracts provide a monthly infection summary. This data is monitored, evaluated, and reported monthly and annually. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the unit manager. There have been no outbreaks since the previous audit.  A facility Covid-19 preparedness framework is implemented at all levels of service delivery. All visitors to the facility are required to sign in electronically, wear a mask, show a vaccine passport on entry, complete a health declaration and covid QR scanning. There are special arrangements in place for children and unvaccinated visitors.
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There were four residents with restraint (lap belt and bedrails) and one resident with an enabler (bedrail). Enabler use is voluntary. All necessary documentation has been completed in relation to the restraints. Staff interviews and staff records evidence that guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers and managing of challenging behaviour has been provided. Restraint has been discussed as part of quality/health and safety meetings. The area manager completes six monthly restraint audits.
Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and	FA	The clinical coordinator is the designated restraint coordinator. Assessment and approval processes for restraint use include the restraint coordinator, registered nurses, resident and/or EPOA/family and medical practitioner.

procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
<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 a comprehensive assessment for each resident who requires restraint or enabler interventions that meets criteria (a) – (h). Assessments are undertaken by either the restraint coordinator or a registered nurse in partnership with the family/whānau and medical practitioner (evidenced in one resident file where a restraint (lap belt) was being used (hospital level) and in one resident file where an enabler (bed rails) was being used (hospital level). In both files reviewed, consents for the use of the restraint/enabler were also completed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint minimisation policy and register identify those restraints are put in place only where it is clinically indicated, justified and approval processes are obtained/met. An assessment form/process is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk.</p> <p>Monitoring forms document regular monitoring at the frequency determined by the risk level, which in the case of the one resident using a restraint was two-hourly.</p> <p>The service has a restraint and enablers register, which is updated each month. Restraint use is audited in the six-monthly internal audit. The completion of restraint forms (e.g. assessments, monitoring forms, six-monthly reviews) are monitored a minimum of monthly by the restraint coordinator.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The service evaluates the use of each restraint or an enabler every six months. In the two files reviewed (one restraint and one enabler), evaluations had been completed with the resident, family/whānau and restraint coordinator.</p> <p>Restraint practices are reviewed every month by the restraint coordinator with data shared at the staff/quality and RN meetings. Evaluation timeframes are determined by policy and risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the</p>	FA	<p>The service actively reviews restraint as part of the internal audit programme and reporting cycle. The restraint minimisation programme is reviewed annually at head office with input provided by each CHT facility including Bernadette. Review processes include policy and procedures review, trends analysis</p>

monitoring and quality review of their use of restraint.		around restraint use and the review of staff education programmes.
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	There is a complaint's register maintained that includes written and verbal complaints, dates and actions taken, however, not all documentation around investigations or resolution was evident.	<p>(i). One complaint related to food was logged on 6 December 2021 and escalated to the unit manager however, there was no investigation and follow up actions recorded. The complaint was unresolved.</p> <p>(ii). One complainant interviewed stated dissatisfaction with the laundry service related to damage of personal clothing. The complainant confirmed the complaint was resolved. The complaint was recorded with no evidence of an</p>	<p>(i). Ensure complaints are dealt with and feedback provided in a timely manner</p> <p>(ii). Ensure investigations and follow up actions are recorded against recorded complaints</p> <p>90 days</p>

			investigation or follow up action.	
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Corrective action plans were documented following each six-monthly internal audit including surveys and individual complaints with sign-off by the unit manager or area manager when achieved. Meeting minutes (staff, quality, and resident) reviewed had an agenda item discussed, there was no evidence that corrective actions or recommendations identified during meetings are addressed and signed off including food and laundry related concerns raised at the resident meeting.</p>	<p>Corrective actions identified in staff, quality and resident meetings are not always addressed, followed up and signed off.</p>	<p>Ensure corrective actions or recommendations identified during meetings are reviewed as signed off when addressed.</p> <p>90 days</p>
<p>Criterion 1.4.1.1</p> <p>Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.</p>	PA Moderate	<p>The organisation has documented policies and procedures regarding the safe use and storage of chemicals within the facility, however these were not being consistently followed by the contracted (outsourced) cleaning service.</p>	<p>(i). Cleaning staff were observed to use chemicals from non-labelled and mis-labelled containers.</p> <p>(ii). Chemicals were present in unlocked sluices.</p> <p>(iii). Three chemical bottles had labels that were illegible.</p>	<p>(i)-(iii). Ensure all chemicals are labelled correctly and stored safely in a manner not accessible to residents and visitors.</p> <p>30 days</p>
<p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p>	PA Moderate	<p>The unit manager interviewed confirm the final upgrade to the nurse call bell system was completed following completion of the renovations. Display screens are situated in all areas are visible throughout the facility and display the room number and wing.</p> <p>Care staff interviewed express their frustration with the technical issues with the call bell system. They reported call bells within certain areas will be activated without a resident in the room and the call bell cannot be</p>	<p>There are ongoing technical issues with the call bell system that has not been fully addressed</p>	<p>Ensure that identified issues are fully addressed.</p> <p>30 days</p>

		<p>cancelled; this can be heard for the duration of the call and do not contribute to work efficiency.</p> <p>A call bell report printed on the day of the audit confirmed call bells in certain rooms had durations of more than one and a half hour on certain days. The call bell is audible throughout the facility for the duration. On the day of the audit the service provider completed a call bell test and the area manager confirm communication is ongoing, but the call bell still provides technical issues.</p>		
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.