

# CHT Healthcare Trust - St Margaret's Hospital and Rest Home

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## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	CHT Healthcare Trust
<b>Premises audited:</b>	St Margaret's Hospital and Rest Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
<b>Dates of audit:</b>	Start date: 5 June 2018    End date: 6 June 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	85

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

## General overview of the audit

St Margaret's Hospital is owned and operated by the CHT Healthcare Trust. The service is certified to provide rest home, dementia, hospital (geriatric and medical) and residential disability (physical) level care. The service provides cares for up to 88 residents with current occupancy of 85 residents.

This surveillance 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 and management.

The service is managed 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.

Two of the three shortfalls identified at the previous audit has been addressed. This was around restraint evaluations and implementation of care. Improvement continue to be required around care interventions.

## 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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Residents and family reported that communication with management and staff is open and transparent. Complaints and concerns have been managed and a complaints register is maintained.

## 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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Services are planned, coordinated, and are appropriate to the needs of the residents. A unit manager is responsible for the day-to-day operations of the facility. She is supported by a clinical coordinator (registered nurse). Quality and risk management processes are implemented. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. The health and safety programme meets current legislative requirements. Adverse, unplanned and untoward events are documented and investigated. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A staff education and training programme is embedded into practice. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Care plans are developed by the registered nurses on the electronic assessment and care planning system who also have responsibility for maintaining and reviewing care plans. Care plans reviewed documented family/whānau involvement where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the diversional therapist. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with the food service.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility has a current building warrant of fitness.

## 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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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. The restraint coordinator is a registered nurse who is responsible for ensuring restraint management processes are followed. On the day of audit there were six residents with restraint and no residents using an enabler. Restraint has been consistently reviewed six monthly for each individual resident.

## 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 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.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	0	1	0	0
Criteria	0	43	0	0	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints procedure is provided to residents and families during entry to the service. Access to complaints forms are located at reception. A record of all complaints received is maintained by the unit manager in hard copy and in an electronic database. There have been 48 complaints since January 2017 (28 related to care). Nine complaints were randomly sampled and documentation, including follow-up letters and resolution (sighted) demonstrated that complaints are being well-managed. One complaint related to a recent power outage and was via the DHB. This has been closed with no actions required. One complaint through the Health and Disability Commissioner in November 2017, had all correspondence provided in requested timeframes and corrective actions around communication have been implemented.</p> <p>It was noted that the complaints register covered everything even minor issues/concerns. They were also generated from monthly resident satisfaction surveys. Complaints were discussed at meetings and handovers. In response to complaints, the service was proactive and there was evidence of RN's attending wound management course, RN reflection meeting, a full review of all resident care plans, and following the power outage complaint debriefs at resident and staff meetings. The 2018, unit manager performance plan had an aim of improving customer satisfaction including specific goals around communication, food services, the activities programme and continued discussion of all complaints at staff meetings.</p> <p>Discussions with residents (three rest home, two hospital and one YPD) and families/whānau confirmed they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly. The information pack for the dementia unit includes information around behaviour</p>



		management, how to make a complaint and excerpts from the complaints policy.
<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>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The policy also describes that open disclosure is part of everyday practice. The care staff (five HCAs, four RNs, two diversional therapists and the cook) interviewed, understood about open disclosure and providing appropriate information and resource material when required.</p> <p>Six families interviewed (four hospital, one rest home and one dementia) confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Fourteen accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.</p> <p>Residents, including younger residents are supported to use communication aids where appropriate.</p> <p>An interpreter service is available and accessible if required through the DHB. Families and staff are utilised in the first instance.</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>St Margaret's Hospital is owned and operated by the CHT. The service provides rest home, dementia, hospital (medical and geriatric) and residential disability (physical) level care for up to 88 residents. Sixty-eight beds are dual-purpose, for rest home and hospital level care, and 20 beds are dedicated dementia beds.</p> <p>Eighty-five residents were living at the facility during this audit. This consisted of five rest home residents including one resident on respite care and one younger person with disability (YPD), sixty-one hospital level residents including four YPD and nineteen residents in the secure dementia unit.</p> <p>The unit manager is a registered nurse (RN) who has been in this role for four years. She has 23 years of management experience in both the disability and private sectors. She is supported by a clinical coordinator/RN that has been in her role for twenty months and has been working at the facility for the past four years. The unit manager reports to the CHT area manager who reports to the CEO.</p> <p>CHT has an overall business/strategic plan, philosophy of care and mission statement. The annual facility-specific business plan links to the organisation's strategic plan and is reviewed monthly with the CEO. The stated objective of the dementia unit is to provide for the safe and therapeutic care of residents affected by dementia in an environment that enhances those residents' quality of life and minimises the risks associated with their "confused" states.</p> <p>The unit manager has completed a minimum of eight hours of professional development relating to the management of an aged care service over the past twelve months.</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 management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>A quality and risk management programme is in place. Interviews with the managers and staff reflected their understanding of 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 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. Policies and procedures are sufficient to guide staff to address the needs of younger residents. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff, evidenced in meeting minutes.</p> <p>Data collected (e.g., falls, medication errors, wounds, skin tears, complaints, infections) are collated and analysed with results communicated to staff in the quality/health and safety (staff) meetings and the RN meetings, evidenced in the meeting minutes. Results are also posted in the staff room for staff to view.</p> <p>Internal audits are completed six-monthly by the area manager. Areas of non-compliance include the initiation of a corrective action plan with sign-off by the area manager when implemented.</p> <p>Residents and relative's surveys are completed monthly and sent to residents with a birthday that month. The response has been overall positive so far. Results are correlated and analysed. The manager improvement plan is linked to resident feedback.</p> <p>An interview with a health and safety representative and review of health and safety documentation confirmed that legislative requirements are being met.</p> <p>The service has a comprehensive emergency plan that was last updated in March 2018. The service managed a power outage following a storm in the region from 10 April 9.00 pm to 12th April midday. A section 31 notification was sent to HealthCERT and there were 84 residents at the time. Two generators were installed, and water was boiled on the BBQ. Disposable plates and cutlery were used, and staff meals were supplied by CHT from a local takeaway. Hoist batteries were recharged at another facility. Wet wipes were used for soiling and additional blankets and clothing were used to keep warm. An emergency telephone was operational throughout and for lighting staff used torches and headlights. Call bells were not operational, so as many residents as possible were cared for in the central lounge with staff presence and otherwise 10 to 15-minute checks were implemented. Medimap was used offline.</p> <p>Falls prevention strategies include a comprehensive investigation of residents' falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. The facility has purchased beds that can be lowered to low levels, and sensor mats. Hip protectors are used to prevent injuries from falls.</p>
<p><b>Standard 1.2.4: Adverse Event</b></p>	<p>FA</p>	<p>An accidents and incidents reporting policy is in place. Adverse events are linked to the quality and risk management programme. There was evidence to support actions are undertaken to minimise the number of incidents. Clinical follow-up of residents, conducted by a registered nurse, was evidenced in all fourteen</p>

Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		<p>accident/incident forms selected for review.</p> <p>Discussions with the unit manager and clinical coordinator confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. A section 31 notification was made relating to the power outage and four have been made relating to pressure injuries.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity, evidenced in all six staff files reviewed (three health care assistants, one registered nurse, one clinical coordinator, one activities coordinator).</p> <p>Copies of practising certificates are kept on file. The service has implemented a general orientation programme that provides new staff with relevant information for safe work practice. Evidence of completed induction checklists were sighted in all six staff files. There are dementia specific induction sections for those working in the dementia unit. Annual staff appraisals sighted were up-to-date.</p> <p>There are 12 RN's plus the clinical manager, eight plus the clinical manager are interRAI trained.</p> <p>An in-service education programme is being implemented. Regular in-services are provided by a range of in-house and external speakers including (but not limited to) nurse specialists, Aged Concern and the Health and Disability Advocacy Service. Eight of the eight HCAs that have worked in the dementia unit for longer than one year have completed their Aged Care Education (ACE) dementia qualification. The other eight HCAs in the dementia unit are in the process of completing these.</p> <p>Competencies are completed for syringe driver, medication, male catheterisation, and peg feeds.</p> <p>In-service sessions consider caring for younger people. Two activity in-services attended by a total of 26 staff, becoming trusted advisors, and managing behaviours that challenge.</p>
Standard 1.2.8: Service Provider	FA	<p>CHT policy includes staff rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents. The clinical coordinator and unit manager (both registered nurses) each work a five-day working week</p>

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>and take month about on call.</p> <p>The facility has six suites, (each suite has either 9 or 10 resident rooms).</p> <p>Across the facility, there are three RN's working morning shifts (three long shifts) and three RN's on afternoon shift (2 long and 1 short) and one RN on night shift.</p> <p>There are two activities staff on Monday to Friday and one activity staff in the sunflower dementia unit in the weekend</p> <p>There are four HCA's and one RN on night shift across the six-rest home and hospital suites. There is one caregiver rostered in the Sunflower dementia unit at night.</p> <p>Suite A – 10 beds (10 hospital residents)</p> <ul style="list-style-type: none"> <li>• AM shift - 2 HCA's (one long shift, one short)</li> <li>• PM shift – 1 HCA (one long shift) and 1 HCA floater 4pm – 8pm between suite A B, C</li> </ul> <p>Suite B- 10 beds (8 hospital residents)</p> <ul style="list-style-type: none"> <li>• AM shift - 2 HCA's (one long, one short shift)</li> <li>• PM shift – 1 HCA (one long shift)</li> </ul> <p>Suite C – 10 beds (10 hospital residents)</p> <ul style="list-style-type: none"> <li>• AM shift - 2 HCA's (one long shift, one short)</li> <li>• PM shift – 1 HCA (one long shift)</li> </ul> <p>Suite D- 10 beds (10 hospital residents)</p> <ul style="list-style-type: none"> <li>• AM shift - 3 HCA's (two long, one short shift)</li> <li>• PM shift – 2 HCA (two long shift) and 1 HCA floater 4pm – 8pm between suite D, E</li> </ul> <p>Suite E – 10 beds (10 hospital)</p> <ul style="list-style-type: none"> <li>• AM shift - 2 HCA's (one long shift, one short)</li> <li>• PM shift – 1 HCA (one long shift)</li> </ul> <p>Suite F – 9 beds and suite G -9 beds (12 hospital and five rest home residents on the day)</p> <ul style="list-style-type: none"> <li>• AM shift 3 HCA's (two long, one short shift)</li> <li>• PM shift – 1 HCA (one long shift); 1 HCA floater 4pm – 8pm between suite F &amp; G</li> </ul>
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		<p>Sunflower 20 beds (20 dementia)</p> <ul style="list-style-type: none"> <li>• AM shift -3 HCA's (two long shifts, one short)</li> <li>• PM shift – 1 HCA (two long shift).</li> </ul> <p>At the time of the audit acuity was reported to be evenly spread throughout the facility. Staffing can be flexible to cover changes in acuity. Extra staff can be called on for increased resident requirements. A stable staff means there are a sufficient number of experienced staff to cover each shift. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</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>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Rest home and hospital residents have their individual medications (unless they require refrigeration or are CDs) stored in a locked drawer in each resident's room. The drawer can only be accessed by staff designated to administer the medications. Medications are stored in a locked cupboard in the dementia unit office. Medication administration practice complies with the medication management policy for the medication rounds sighted. Medication prescribed is signed as administered on the electronic medication documentation system. Registered nurses administer medicines. All staff that administer medication are competent and have received medication management training. The RN on duty reconciles the delivery and documents this. Medication charts are documented in the electronic medication system by the prescribing doctors. For the 14 medication charts reviewed electronically, all documentation met legislative requirements and relevant guidelines. No residents currently self-administer medicines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a fully equipped commercial kitchen, which is located centrally in the facility. The majority of food is prepared and cooked on-site by the contracted kitchen staff. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RNs on duty. The kitchen staff have completed food safety training. The kitchen manager and cooks follow a rotating seasonal menu which has been reviewed by a dietitian. The temperatures of refrigerators and freezers are recorded. There is special equipment available for residents if required. Snacks are available at all times in the dementia unit.</p> <p>All food is stored appropriately. Residents and the family members interviewed were very happy.</p>
Standard 1.3.5:	PA	<p>The service is implementing a computer-based care planning system. All of the resident care plans and files are</p>

<p>Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>Moderate</p>	<p>now transferred over to the new software, including the seven resident files reviewed. All care plans reviewed reflected the interRAI assessment, but did not provide interventions for all assessed needs or needs identified through progress notes. Caregivers interviewed were well informed regarding resident care needs. Care plans reviewed evidence multidisciplinary involvement in the care of the resident. Care plan interventions remain a shortfall from the previous audit. Short-term care plans were not always documented and did not always include interventions for care.</p> <p>There is evidence of service integration with documented input from a range of specialist care professionals including: the podiatrist, physiotherapist, dietitian and mental health care team for older people. The care staff advised that the care plans are easy to follow.</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>Care plans sampled were goal orientated (link 1.3.5.2). The staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently if necessary. Monitoring records sighted (weights, food and fluids and turning charts). Pain monitoring were documented on medimap.</p> <p>There were seven residents with wounds at the time of the audit in the hospital/rest home. There were four residents with wounds in the dementia unit. One resident had a (healing) unstageable pressure injury. Assessments, management plans and documented reviews were in place for all wounds. This is an improvement from the previous audit.</p> <p>Specialist nursing advice is available from the DHB as needed. A physiotherapist is available one day during the week to assist with mobility assessments and the exercise programme.</p> <p>Residents and family members interviewed confirmed their satisfaction with care delivery.</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</p>	<p>FA</p>	<p>The service continues to employ three activities coordinators (one full time and two part-time) to operate the activities programme for all residents over seven days. Two of the three activities coordinators are trained diversional therapists. Healthcare assistants also provide activities in the dementia unit.</p> <p>Each resident has an individual activities assessment on admission and from this information an individual activities plan is developed as part of the care plan by the registered nurses with input from the activities staff. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. All long-term resident files sampled have a recent activity plan within the care plan and this is evaluated at least six monthly when the care plan is evaluated. Plans sampled in the dementia unit document activities to support the resident over the 24-hour period and each resident in the dementia unit now has a 24-hour care plan on the wall in their room to provide quick reference for visitors and staff. Younger residents are encouraged to remain</p>

service.		as active as possible within the community and to engage in age appropriate personal interest activities. Residents and families interviewed commented positively on the activity programme.
Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents are reassessed using the interRAI and the computerised care planning system at least six-monthly or if there has been a significant change in their health status. Long-term care plans are then evaluated and rewritten or updated (link 1.3.5.2). There was documented evidence that care plan evaluations were current in resident files sampled. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes. The registered nurses interviewed explained the communication process with the GP.
Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed that expires on 15 September 2018. All medical and electrical equipment has been serviced and/or calibrated. Hot water temperatures are monitored and are managed within 43-45°C. The facility has sufficient space for residents to mobilise using mobility aids. The external area is well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.
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 CHTs infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at 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.
Standard 2.1.1: Restraint	FA	There are policies around restraints and enablers. Six residents (hospital level) were using restraints and no residents were using an enabler. Staff receive mandatory training around restraint minimisation. All care staff

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>interviewed understood the difference between an enabler and a restraint.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>In the two restraint files sampled, restraint use has been reviewed on a CHT restraint assessment and consent evaluation form six-monthly (at a minimum). This is an improvement since the previous audit. The form used includes all aspects of 2.2.4.1 (a) to (k). A monthly restraint report is completed by the restraint coordinator and is signed off by the unit manager each month. This report is discussed at each (monthly) RN meeting.</p>



## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA</p> <p>Moderate</p>	<p>The service uses a computer based assessment and care planning system. Once the care plan has been developed it is printed off for the family to sign and then kept in a separate folder in the nurses' station for caregivers to access. All residents had a care plan documented, however, care plans had not been personalised for individual residents and did not document all resident care needs. Short-term care plans were not always documented and did not always include interventions for care.</p>	<p>(i) Two of two hospital care plans did not include all interventions to safely guide resident care. (a) One file did not document interventions around moving and handling, management of weight loss, the need for two hourly turns, and management of behaviours that challenge. (b) One file did not document interventions around pain management and pressure injury prevention, and included contradictory advice regarding moving and handling.</p> <p>(ii) One of two rest home care plans did not include interventions to support management of behaviours that challenge.</p> <p>(iii) One of one younger person (YPD) care plan did not include interventions to identify resident's current abilities i.e.: self-feed</p>	<p>(i)-(iii) Ensure that care plans are individualised to resident needs and include all interventions to safely guide care. (iv)-(v) Ensure that short-term/acute changes in care have a documented short-term care plan and documented resolution or the long-term care plan updated.</p> <p>60 days</p>

			<p>and management of supra-public catheter.</p> <p>(iv) Short-term care plans implemented, documented a goal and regular evaluations but no interventions (one YPD, one rest home).</p> <p>(v) Acute or short-term changes in care needs did not always have a short-term care plan documented or the long-term care plan updated (one YPD, one hospital and one dementia).</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.