

# CHT Healthcare Trust - Waiuku Hospital and Rest Home

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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 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>	Waiuku Hospital and Rest Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 23 July 2018    End date: 24 July 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>	59

# 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

CHT Waiuku is owned and operated by the CHT Healthcare Trust. The service provides care for up to 60 residents requiring hospital and rest home level care. On the day of the audit, there were 59 residents. A unit manager, who has been at the service for six months oversees the service 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 service standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff and management.

This audit has identified areas requiring improvement around the quality programme, care planning, evaluations, environmental temperatures, and civil defence.

## 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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Staff at CHT Waiuku strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is easily accessible to residents and families. Policies are implemented to support residents' rights. Informed consent processes are followed, and residents' clinical files reviewed evidence informed consent is obtained. Staff interviews inform a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are promptly managed.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The area manager and quality manager provide governance and support to the unit manager. The unit manager is also supported by a clinical coordinator, registered nurses and care staff. The quality and risk management programme includes a service philosophy, goals and a quality planner. Quality activities are conducted. Residents' meetings are held, and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. An education and training programme has been implemented. Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Resident information is appropriately stored and managed.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is a comprehensive information package for residents/relatives on admission to the service. Assessments, risk assessments, care plans, interventions and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Residents and family interviewed, confirmed they were involved in the care plan process and review. The general practitioner completes an admission visit and reviews the residents at least three-monthly.

The activity team provides a varied and interesting activities programme for each resident group. The activity programme meets the abilities and recreational needs of the group of residents including outings and entertainment.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three-monthly.

The menu is designed by a dietitian at an organisational level and provides a range of dietary options that ensures individual and special dietary needs are accommodated.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility.

There are adequate numbers of communal toilets. There is sufficient space to allow the movement of residents around the facility. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible.

There are policies in place for emergency management. There is a person on duty at all times with first aid training. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed off-site

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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CHT Waiuku has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were five residents with restraint and one resident with an enabler. Individual restraint management processes are adhered to.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

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 the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are 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	45	0	4	1	0	0
Criteria	0	95	0	5	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 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Code of Health and Disability Services Consumer Rights (the Code) has been incorporated into care. Discussions with two registered nurses and four health care assistants identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with five residents (three rest home and two hospital) and five family members (one rest home and four hospital) confirmed that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in eight resident files (four hospital and four rest home, including one resident funded through short-term interim funding), were signed by the resident or their enduring power of attorney (EPOA). Written consents were sighted for specific procedures.</p> <p>Advanced directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the resident's file where required. Four healthcare assistants and two registered nurses (RNs) interviewed, confirmed verbal consent is obtained when delivering care.</p> <p>Resident files of long-term residents have signed admission agreements, and the interim funding care resident has a signed short-term agreement.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>There is a policy that describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate.</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 interviewed confirmed that relative/family visiting could occur at any time.</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>	FA	<p>The service has a complaints policy that describes the management of the complaints process. There is a complaints' form available. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints' register. Two complaints were received in 2017 and three in 2018. Complaints have noted investigation, corrective actions and resolutions. Results are provided to complainants and feedback is provided to staff. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Code of rights leaflets are available in the front entrance foyer and throughout the facility. Code of rights posters are displayed. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance. If necessary, staff will read and explain information to residents. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement as evidenced in the sample files reviewed.</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>The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff interviewed were knowledgeable about respecting resident's privacy and described how they manage to maintain privacy and respect of personal property. All residents interviewed stated their needs were met. A policy describes spiritual care. Church services occur on a regular basis. All residents interviewed indicated that residents' spiritual needs are being met when required. The files reviewed did not always identify that cultural and/or spiritual values, individual preferences are identified (link 1.3.5.2). Residents and families interviewed confirmed that staff are respectful and caring, and maintain their dignity, independence and privacy at all times.</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 established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. Two residents identified as Māori on the day of the audit. Cultural and spiritual practice is supported, however identified needs are not always incorporated into the care planning process (link 1.3.5.2). Discussions with staff confirmed that they are aware of the need to respond to cultural differences.</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>The cultural service response policy guides staff in the provision of culturally safe care. Regular reviews were evident, and the involvement of family/whānau was recorded in the resident care plan, however care plans did not always reflect identified needs around cultural and spiritual needs (link 1.3.5.2). Residents and family interviewed feel that they are involved in decision making around the care of the resident. Spiritual and pastoral care is an integral part of service provision. Regular church services are provided to residents. Residents social and recreational needs were documented in the sample of files reviewed. Staff receive training on cultural awareness.</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 service has policies and procedures in place which states there will be zero tolerance against any discrimination occurring. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination free environment. The Code of Rights is included in orientation and in-service training. Training is provided as part of the staff training and education plan. Interviews with staff confirmed their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identified that privacy is ensured. Discussions with the nurse manager confirmed, and a review of complaints identified no complaints of this nature.</p>

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service has policies to guide practice that aligns with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Staffing policies include the requirement to attend orientation and ongoing in-service training.</p> <p>The service has implemented a quality project around management of palliative residents and end of life care. This includes good communication links with Franklin Hospice and involvement with Palliative Outcome Initiative. The clinical coordinator has undertaken hospice training and is the Link Nurse for Franklin. Hospice provides ongoing training for RN's &amp; HCA's. Training was provided for staff in completion of advanced care plans, pain management and death &amp; dying. Hospice provides syringe driver training for RN's with annual updates.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Fourteen incidents/accidents forms, June and July 2018, were reviewed and included a section to record family notification. All forms indicated family were informed or if family did not wish to be informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>CHT Waiuku is owned and operated by the CHT Healthcare Trust. The service provides rest home and hospital (geriatric and medical) level care for up to 60 residents. On the day of the audit, there were 59 residents in total, 20 rest home level and 39 hospital level. This includes one resident (rest home level) on an interim care contract. All rooms are dual-purpose.</p> <p>The unit manager is a registered nurse and maintains an annual practicing certificate. She has been in the manager role at the facility for six months and has experience in management. A clinical coordinator who has been in the position for one year has five years' experience in aged care management. The area manager has been in the role for four months. The unit manager reports to the area manager weekly, on a variety of operational issues. CHT has an overall business/strategic plan and CHT Waiuku has a facility quality and risk management programme in place for the current year. The unit managers performance plan was reviewed in May to incorporate objectives from the strategic</p>

		<p>plan. The organisation has a philosophy of care, which includes a mission statement.</p> <p>The unit manager has completed in excess of eight hours of professional development in the past 12 months.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the absence of the unit manager, the clinical coordinator is in charge, with support from the area manager, the senior registered nurse and care staff.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>There is an organisational business/strategic plan that includes quality goals and risk management plans. Interviews with staff confirmed that quality data is discussed at monthly staff meetings to which all staff are invited, however minutes of meetings do not always reflect this. A falls graph is attached to meeting minutes. The unit manager advised that she is responsible for providing oversight of the quality programme. The quality and risk management programme is designed to monitor contractual and standards compliance. Head office provides monthly quality data stats. There was no documented evidence that the stats were analysed to identify trends and corrective actions where needed. The service's policies are reviewed at national level, with input from facility staff every two years. New/updated policies are sent from head office. Staff have access to manuals. Resident/relative meetings are held three-monthly. Restraint and enabler use is reported within the clinical and staff meetings.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule is completed 6 monthly and was last completed April 2018. Areas of non-compliance identified through internal audits were not always actioned for improvement.</p> <p>The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Residents/relatives satisfaction surveys are sent out to selected residents each month. Results are correlated and analysed at head office. The results are forwarded to CHT Waiuku for action, however corrective actions were not established as a result of the satisfaction data collected.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an accidents and incidents reporting policy. The unit manager investigates accidents and near misses and analysis of incident trends occurs. Staff interviewed confirmed there is discussion of incidents/accidents at monthly clinical and staff meetings including actions to minimise recurrence, however this is not reflected in meeting minutes (link 1.2.3.6). Fourteen resident incident forms sampled demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Discussions with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There were appropriate notifications made around two pressure injuries in 2018.</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. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Eight staff files were reviewed (one clinical coordinator, two registered nurses, one activities coordinator and four health care assistants) and evidenced that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2017 has been completed and a plan for 2018 is being implemented. The unit manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Five of the six registered nurses and the clinical coordinator have completed interRAI training.</p> <p>Careerforce is available for caregivers. The majority have completed Careerforce level 2 or 3. Caregivers and RNs complete manual handling competencies and medication.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>CHT policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The unit manager works Monday to Friday, supported by weekly visits from the area manager. There is a clinical coordinator who works full-time from Monday to Friday. The unit and clinical coordinator are available during weekdays and share the on-call after hours. Adequate RN cover is provided 24 hours a day, seven days a week. Sufficient numbers of caregivers support the clinical coordinator and RNs. Staff interviewed, advised that there are sufficient staff on duty at all times.</p> <p>The service is split into five wings and staffed separately. Two RNs are rostered on full shifts and share all five wings for both morning and afternoon shifts. One RN works across the five wings on night shift. The night shift RN is supported by three HCAs.</p>

		<p>The ten-bed Bayview (four rest home and six hospital residents) and ten-bed Sandspit (two rest home and eight hospital residents) wings, both have one full shift HCA and share a short shift HCA on morning and afternoon shifts.</p> <p>Portside wing has 12 beds (three rest home and eight hospital residents) and Riverside wing has ten beds (two rest home and seven hospital current residents) both have a full shift HCA and share a short shift HCA on both morning and afternoon shifts.</p> <p>The Edgewater wing has 19 beds (nine rest home and ten hospital residents) and has two HCAs (one long shift and one short shift) on morning and afternoons. An additional five-hour morning shift provides support across all five wings.</p> <p>Residents and family members interviewed reported that there are adequate staff numbers to attend to 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 record. 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 cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant health care assistant or registered nurse.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. Information gathered on admission is retained in residents' records. The relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The admission agreements reviewed aligns with the service's contracts.</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. Transfer notes and discharge information was available in resident records of those with previous hospital admissions.</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 policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with current medication guidelines. Medication reconciliation is completed by the RN on delivery of medication and any errors fed back to pharmacy. Registered nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. Care staff interviewed were able to describe their role regarding medicine administration. Education around safe medication administration has been provided. Medications were stored safely. Medication fridges were monitored weekly and all temperatures were within the acceptable range. There were no expired medications. All eye drops, and creams were dated on opening. There were no residents who self-administer medications.</p> <p>Sixteen medication charts were reviewed on the electronic medication system. All medication charts reviewed have 'as required' medications prescribed with an indication for use. The effectiveness of 'as required' medications is entered into the electronic medication system. Medication charts had been reviewed at least three-monthly.</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>All food and baking are prepared and cooked on-site by a contracted service. The chef/kitchen manager is supported by a second chef, cooks and kitchen assistants. All staff have been trained in food safety and chemical safety. 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.</p> <p>The kitchen can meet the needs of residents who require special diets. The RNs inform the kitchen manager of any residents with specific nutritional needs, food allergies, or food likes or dislikes. The kitchen manager and cooks follow a rotating seasonal menu, which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served (link to 1.4.7.1).</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</p>	FA	<p>Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p>



organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Risk assessments have been completed on admission and reviewed six-monthly as part of the evaluation process. The outcomes of interRAI assessments and risk assessments that were reflected in the care plans reviewed. Additional assessments such as behavioural, wound and restraints have been completed according to need.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Care plans reviewed demonstrated service integration and input from allied health. Support needs and interventions were not always documented to reflect the resident goals and the resident's current health status. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations. Residents (if appropriate) and family stated they were involved in the care planning and review process.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP/NP visit or nurse specialist consultant. Short-term care plans are developed for infections.</p> <p>Wound assessments, treatment and evaluations were in place for ten identified wounds (skin tears, chronic ulcer, two grade two pressure injuries and one grade three pressure injury) (link to 1.3.5.2 as one resident with a minor wound had no wound plan). There is access to a wound nurse specialist at the DHB. Adequate dressing supplies were sighted in the treatment rooms.</p> <p>Continence products are available and resident files include a continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring forms in place include (but not limited to); monthly weight, blood pressure and pulse, neurological observations post unwitnessed falls or identified head injuries, food and fluid charts, pain monitoring, blood sugar levels and behaviour charts. Progress notes document changes in health and significant events.</p>
Standard 1.3.7: Planned Activities Where specified as part of the	FA	There is a team of four activity coordinators, one of whom is undertaking level four Diversional Therapy training. The team coordinate and implement the activity programme, and the programme is across

service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		<p>seven days a week. The programme is integrated to meet the physical and psychosocial well-being of the residents. The programme includes new activities when requested by residents and is varied. There are regular outings into the community. One-on-one activities such as individual walks, reading and chats and hand massage occur for residents who choose not to be involved in group activities. Themes and events are celebrated.</p> <p>Residents interviewed spoke very positively about the varied activities programme which they have input into. Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate, are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>Five of eight care plans had been evaluated by registered nurses' six monthly. Two residents had not been at the service six months and one resident care plan was for a short-term interim funding contract. Evaluations did not always describe the resident's progress against the resident's identified goals. Changes to care are updated on the long-term care plan. The services use the interRAI tool as the main evaluation process. There is at least a three-monthly review by the medical practitioner.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the residents' files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents' files. Discussions with the clinical coordinator and RNs identified that the service has access to a wide range of support through the GP, nurse specialists, hospice and contracted allied health services.</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,</p>	FA	<p>There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety datasheets and product use information was readily available. Staff have attended chemical safety training.</p>

infectious or hazardous substances, generated during service delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>The building has a warrant of fitness that expires 17 September 2018. There is a full-time maintenance person who works over four facilities. The maintenance person ensures daily maintenance requests are addressed. He maintains a monthly planned maintenance schedule. Essential contractors are available 24 hours a day, seven days a week. Electrical testing and annual calibration have been completed. Hot water temperatures in resident areas are monitored three-monthly. Temperature recordings reviewed were between 43-45 degrees Celsius.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Residents were observed to safely access the outdoor gardens and courtyards. Seating and shade is provided. The heaters in the hallways were very hot to touch.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the residents' care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There is an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Several bedrooms have their own ensuites. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</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 were of an appropriate size to allow the level of care to be provided and for the safe use and manoeuvring of mobility aids including hoists. Residents are encouraged to personalise their bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation,</p>	FA	<p>The communal areas include the main lounge and several smaller lounges and four separate dining</p>

<p>And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>areas. The communal areas are easily and safely accessible for 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>The facility is cleaned by contracted cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All laundry is done off-site except kitchen and personal items. Residents and relatives interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	PA Low	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management is included in the mandatory in-service programme. There is a first aid trained staff member on every shift. The facility has an approved fire evacuation plan and fire drills take place six monthly. Smoke alarms, a sprinkler system, exit signs, emergency lighting and gas cooking facilities are in place. There are civil defence kits in the facility and adequate water storage on-site.</p> <p>The call-bell system is evident in resident's rooms, lounge areas, and toilets/bathrooms. Staff confirmed that they conduct security checks at night.</p> <p>The service does not have enough food stocked for three days.</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>General living areas and resident rooms are appropriately ventilated and heated (link to 1.4.2.4). All rooms have external windows with plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control</p>	FA	<p>CHT Waiuku has an 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. It is linked</p>

management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.		into the incident reporting system. A registered nurse is the designated infection control coordinator with support from the unit manager, the clinical coordinator and all staff as the quality management committee (infection control team). Minutes are available for staff (link 1.2.3.6). Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	A registered nurse at CHT Waiuku is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme, for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. 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.
Standard 3.3: Policies and procedures 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.	FA	There are CHT infection control policies and procedures appropriate for the size and complexity of the service. 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. The policies have been reviewed and updated.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	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 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 visitors that is appropriate to their needs and this is documented in medical records.

<p><b>Standard 3.5: Surveillance</b></p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is described in CHTs infection control manual. The surveillance policy described the purpose and methodology for the surveillance of infections. Definitions of infections in place appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the resident files. Short-term care plans are used. Infections are included on an electronic register and the infection prevention and control officer completes a monthly report. This data is monitored and evaluated monthly and annually. Interviews with staff confirmed monthly data is reported to the combined infection prevention and control, health and safety and staff meetings, however trends and required training are not documented (link 1.2.3.6). The infection prevention and control officer use the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks since the previous audit.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were five residents with restraint and one resident with an enabler. All five residents have bed rail restraints and one of these also used a lap belt as restraint. The enabler in use is a bed rail. The enabler file sampled documented that enabler use is voluntary. All necessary documentation has been completed in relation to the restraints. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff training/education on restraint/enablers has recently been provided in June 2018. A registered nurse is the designated restraint coordinator.</p>
<p><b>Standard 2.2.1: Restraint approval and processes</b></p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers</p>	FA	<p>A registered nurse is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner.</p>

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 comprehensive individual assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in three restraints and one enabler resident files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the files reviewed, assessments and consents were fully completed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified, and approval processes are obtained/met. An assessment form is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular monitoring at the frequency determined by the risk level were present in the files reviewed. There is a restraint register as part of monthly reports.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. 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 monitoring and quality review of their use of restraint.</p>	FA	<p>The service reviews restraint as part of the internal audit and reporting cycle. The restraint coordinator completes the restraint review; and reports to the staff and clinical meetings.</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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	The clinical coordinator is responsible for collecting adverse event data and implementation of the internal audit programme, as per the internal audit schedule. Quality improvement data is collected around falls, skin tears, infections, and other adverse events, but there is little evidence to support that this data is being trended and analysed. Staff are informed regarding the number and type of adverse events each month but are not informed around trends in data or what the data is reflecting. Staff are informed of internal audit results, as evidenced in staff meeting minutes (link 1.2.3.8).	Quality data is not being trended and analysed. Meeting minutes did not evidence that quality data and outcomes are reported.	Ensure that the quality data collected is trended and analysed, and that this information is shared with staff.  90 days



<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>	<p>PA Low</p>	<p>A corrective action planning process is to be completed where internal audits and satisfaction surveys reflect sub-optimal results. However, corrective action plans were not consistently being established when required. Where corrective action plans are developed, there are gaps in the documentation around implementation and sign-off of these corrective action plans.</p>	<p>i) Corrective action plans are not regularly being developed where opportunities for improvement are identified.</p> <p>ii) Where corrective action plans are documented, there is a lack of consistent evidence of these plans being implemented, with sign-off by the person(s) responsible.</p>	<p>i) Ensure corrective action plans are established where opportunities for improvements are identified.</p> <p>ii) Ensure that established corrective action plans are implemented and are signed-off by the person(s) responsible.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment</p>	<p>PA Moderate</p>	<p>All eight resident files reviewed included an up-to-date electronic care plan. Not all interventions were documented to support assessed needs in the long-term care plans reviewed. During the admission process, the registered nurse, along with the resident and family/whānau, discuss cultural and spiritual considerations, however this was not always reflected in individual care plans. Regular reviews were evident, and the involvement of family/whānau was recorded in the resident care plan. Interviews with staff evidenced that staff were familiar with care needs for all residents. Both residents and families interviewed stated that the care provided was very good. The GP described the clinical</p>	<p>(i) Two initial care plans had not been fully completed (one hospital and one rest home level).</p> <p>(ii) Two of four hospital care plans did not include all interventions to support assessed needs; both did not include changes to manual handling (hoisting needs), one did not include the risks associated with restraint and the other did not include the need for a puree diet (noting the kitchen was aware).</p> <p>(iii) Three of four rest home level care plans</p>	<p>Ensure that care plans document the care and support needed for each resident.</p> <p>60 days</p>

process.		care as 'very good' and described the staff as very caring and proactive. Interviews identified current needs were being provided for residents.	<p>did not include interventions for safe care.</p> <p>(a) Care plan one did not include interventions for safe smoking, interventions and support for panic attacks, and the care plan described the use of oxygen which was not prescribed (Noting, staff interviewed stated oxygen was not being given). (b) Care plan two did not include the need to elevate feet and pressure injury care. The care plan had incorrect mobilising interventions and there was no wound plan for an identified minor wound being dressed. (c) Care plan three did not include all triggers from the interRAI including falls.</p> <p>(iv) Care plans reviewed do not always reflect cultural or spiritual needs including those of two Māori residents</p>	
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	Of the eight resident care plans reviewed, five were for residents who had been with the service for over six months. All five had been reviewed using the interRAI tool and the care plan updated six monthly. There was no documented evaluation of care.	<p>Five long-term care plans reviewed did not include a documented evaluation of care against stated goals.</p>	<p>Ensure an evaluation of care and progress towards stated goals is documented at least six monthly.</p> <p>60 days</p>
Criterion 1.4.2.4	PA Low	The service was warm and homely on the day of audit and communal areas are spacious and appropriate to the	The night store heater in the hallways were very hot to touch and were a	Ensure that the residents

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.		client group. The heaters were very hot to touch.	potential burning hazard to residents.	are protected from the direct heat from the night store heaters.  90 days
Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.	PA Low	The service has emergency equipment and civil defence equipment readily available. There is not enough food stored on-site for three days.	The service does not maintain a stock of food for three days in case of emergencies.	Ensure that there are sufficient stocks of food available for three days of meals for residents.  60 days

## 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.